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H.R. 2379, THE RURAL VETERANS ACCESS TO CARE ACT OF 2003; AND H.R. 3094, THE VETERANS TIMELY ACCESS TO HEALTH CARE ACT

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS

HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTH CONGRESS

FIRST SESSION

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H.R. 2379, THE RURAL VETERANS ACCESS TO CARE ACT OF 2003; AND H.R. 3094, THE VETERANS TIMELY ACCESS TO HEALTH CARE ACT

TUESDAY, SEPTEMBER 30, 2003

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC

The subcommittee met, pursuant to notice, at 2:30 p.m., in room 340 Cannon House Office Building, Hon. Rob Simmons (chairman of the subcommittee) presiding.

Present: Representatives Simmons, Baker, Renzi, Boozman, Brown-Waite, Murphy, Rodriguez, Snyder, and Strickland.

OPENING STATEMENT OF CHAIRMAN SIMMONS

Mr. SIMMONS. The subcommittee will come to order. If we could secure the doors.

I want to welcome my fellow members, distinguished witnesses, and others in attendance. This is a legislative hearing to consider two bills referred to the subcommittee. The first bill, H.R. 2379, was introduced by the distinguished gentleman from Nebraska, Mr. Tom Osborne, also known as Coach Osborne. It is good to have you here. The Rural Veterans Access to Care of 2003 attempts to improve access to VA health care for veterans who live in rural and remote areas.

The second bill was introduced on September 16th of this year by my fellow committee member, subcommittee member, the gentlewoman from Florida, Ms. Ginny Brown-Waite and others. Good to have you here, Ginny. H.R. 3094, the Veterans Timely Access to Health Care Act, would establish standards of access to care for veterans seeking primary care from the Department of Veterans Affairs.

As a life member of the American Legion and a Vietnam veteran, I believe that veterans should not have to wait or wonder whether they will get medical services from the VA. Access to timely VA health care is an important issue that this subcommittee has examined, discussed, and struggled with in this session and in past Congresses.

The GAO, the General Accounting Office, has issued two reports on the subject of access and waiting times, highlighting VA's slow and often spotty improvements from 1999 to 2001.

Also, the report of the President's Task Force to Improve Health Care Delivery for our Nation's Veterans was issued this year and echoed the same concerns about waiting times and VA's inability to meet its own published access standards.

Delayed health care is denied care. The task before us is to examine two potential legislative solutions for veterans living in rural or remote areas and for veterans seeking primary care appointments.

Mr. Osborne's bill would set aside at least 5 percent of the available appropriation each year to invest in access to care for rural veterans. The bill would also require the Secretary to issue certain regulations and conduct periodic reviews of the operational provisions of the bill and the allocation of funds.

The bill introduced by Representative Ginny Brown-Waite would establish access standards in law for veterans seeking VA primary health care. Long before the President's Task Force was formed, the former Under Secretary for Health, Dr. Tom Garthwaite, testified before this Committee, and I quote, "VHA is committed to providing timely care to the veterans enrolled in our health care system. We have recently developed a data system and performance expectations with regard to waiting times for primary care and specialist consultation. We believe that our performance goals for waiting times, commonly known as '30–30–20,' are industry leading and fully support patient expectations for timely access to care. Our strategic goal is to provide 90 percent of new primary care and specialty care visits within 30 days and see 90 percent of patients within 20 minutes of their scheduled appointment time." Ms. Brown-Waite's bill would codify part of what VA has claimed in public to be its policy for more than 3 years.

Now I would ask my friend, Mr. Rodriguez from Texas, if he has an opening statement that he would like to make.

OPENING STATEMENT OF THE HONORABLE CIRO D. RODRIGUEZ

Mr. RODRIGUEZ. Thank you, Mr. Chairman. Good afternoon to everyone. I appreciate your holding this important hearing today. And I would like to welcome everyone here and also and also the opportunity to be able to deal with these two issues that are before us.

As with many things, there seems to be a consensus on the problems and we do have a problem in rural America just like I have it in my own backyard. But there seems to be too much on the consensus in terms of the solution that will address that problem. And by and large I think as Democrats we believe that more resources are needed to the VA to address the problems that are attributed to inadequate funding as we see it now. That is why so many of us believe in the mandatory funding for VA health care. I hope we have changed a least an opportunity to dialogue in terms of the problems that confront us at this point in time.

Another important process is taking place in the VA right now, which could have implications for veterans access for the next two decades. And I hope, Mr. Chairman, it is critical for this committee to hold hearings on the Capital Asset Realignment for Enhanced Services, or CARES, plan where the VA has proposed to transform

its infrastructure. Mr. Chairman, as you well know, Congresswoman Brown-Waite introduced a similar bill which we were to mark shortly before the summer break and then we got postponed around that time. And then we have a chance now to look at it. And so I appreciate your scheduling this opportunity.

One concern is that the diversion of resources shifting care from almost every network into primary care settings in the private sector. Although the VA has documented improvements, there are still many veterans waiting longer than 30 days for primary care appointments. Dr. Roswell will tell us that none of the networks would currently meet the 90 percent compliance rate for the average percentage of enrolled veterans who are able to schedule primary care appointments within 30 days. That means that every network would have to provide contract care to some veterans. Unfortunately, the VA may not receive what any of us consider to be adequate appropriations. And at the present time just to continue with existing resources, we still are asking for the $1.8 billion, as you well know.

And by the proposed legislation that we have, I think that 5 percent is $1.2 billion. If you ask for additional money in addition to the $1.8 and $1.2 and ask us for three, I might be very favorable in supporting it. But I believe this bill would have the unintended consequences of forcing VA to either cut more veterans off or to further limit the services, such as long-term care and mental health that it provides to our veterans.

We also be considering H.R. 2379 produced by the gentleman from Nebraska, Mr. Osborne. In parts of my district, mine is 200 miles going south. Yet, my understanding, based on this 5 percent cut, my district would be not receiving those resources. So some rural areas would. Others wouldn't. And so I would have some concerns with that. Veterans in the McClellan area of Texas must travel up to six hours one way to reach the San Antonia VA Medical Center. So I am well acquainted with the access problems Congressman Osborne is trying to address. But I am not sure that we completely understand the implications of this particular piece of legislation.

The VA says only 1.6 percent of the enrollees would be considered geographically remote. Yet, we are asking for 5 percent of the money when only 1.6. So it is a little disproportional there. So we want to look at reaching out to rural America. Somehow we really need to look at additional resources instead of taking from the existing one.

So as we attempt to standardize access throughout the Nation, I am not sure this would represent an improvement in addressing these problems.

I want to thank the members that are here. Dr. Snyder, thank you for being here. And looking forward to continue working with you and look forward to your testimony.

Mr. SIMMONS. Thank you, Mr. Rodriguez. Welcome to our first panel. We have two colleagues, Members of Congress, here to testify, beginning with Tom Osborne of Nebraska, who introduced the Rural Veterans Access to Care Act of 2003. I would like to note for the record, and I believe this is correct, that Tom served his coun-

try 6 years in the Army National Guard and Army Reserves. Thank you for your service, Tom.

We are also joined by Jon Porter of Nevada, who has joined us to provide us his testimony on the legislation we are considering. Thank you, Jon, for coming. We were originally scheduled to have Representative Stenholm of Texas. He cannot make it. But without objection, I will make his statement a part of the record. Hearing no objection, that is done.

[The statement of Congressman Stenholm appears on p. 81.]

Mr. SIMMONS. Tom, why don't we start with your testimony.

STATEMENTS OF THE HONORABLE TOM OSBORNE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEBRASKA, AND THE HONORABLE JON C. PORTER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEVADA

STATEMENT OF THE HONORABLE TOM OSBORNE

Mr. OSBORNE. I would like to thank the chairman for having this hearing and appreciate Mr. Rodriguez's comments. And thank the rest of the committee for being here. I know some of you had to come back early.

The first thing I would like you to do is consult this map. I think you have it. And get an idea of what the problem is. Circled are the VA clinics. In Omaha, which is here at the corner of Nebraska, that is the only VA hospital in the State of Nebraska. The other circled towns are the clinics. So we have a number of people who are eight or nine hours from Omaha, the VA hospital. And a great many people who are anywhere from 100 to 150, 200 miles from the clinics. So you might just take a look at that. You may say, "Well, Nebraska is an anomaly." And this is a fairly typical Midwestern State.

And so if you look at the cosponsors of the bill, you will see people from New York State, you will see people from Florida. So almost every VISN has a number of people who are geographically remote from a clinic or a VA hospital.

So I just wanted to make sure that people understand that when you have bad weather, you have older veterans, when you have those who are critically ill, it is impossible for a great many of them to access VA health care. So this is what this bill attempts to address.

Veterans often wait, as you have mentioned, 6 months to 1 year for health care. And, of course, this is a real difficult time. So wait time, distance, age, and infirmity result in many not receiving any care at all. If you are 90 or 100 miles or 200 miles from a VA hospital or a facility and you are 85, 90 years old and the weather is bad, you are obviously not going to go. And so many people simply don't get care.

VISN–23, of which my district is part, includes Iowa, Minnesota, Nebraska, North Dakota, South Dakota, parts of Illinois, Kansas, Missouri, Wisconsin, and Wyoming, it is 390,000 square miles. And in that area there are 360,000 veterans. And I would like to have you listen carefully to this. Out of 360,000 veterans, 90,000 are geographically remote under this legislation, which is 25 percent. And

this is not atypical. So we are not just talking about just a tiny fraction. We are talking about a large number of veterans.

The provisions of H.R. 2379 are as follows: A qualifying veterans is one who is more than 60 miles from the VA facility. Now it could be that if you are in West Virginia and you are 30 miles away and there is a mountain range between you and the facility, the VA can say, well, we are going to include somebody that is 30 miles away because they are going to have an awful hard time getting here in two hours even. So there is flexibility. But generally speaking 60 miles or more from the facility.

And such veterans may receive routine health care, such as acute or chronic symptom management, not your therapeutic medical services. Other services deemed appropriate by the director of the VISN after consultation with a VA primary care physician. Now that is important to understand. We are not talking about a voucher where somebody is just given a certain amount of money and go get your health care anywhere you want. There has to be consultation with a primary VA physician. And then the VISN director has to agree that this is a person who is somewhat geographically remote and handicapped by distance. So they can receive locally services at a local health care facility if approved by the VA.

Now some of the procedures that I know personally, a pacemaker, you have to have that checked about four times a year. Now if you have got to wait 6 months or drive 200 miles to get your pacemaker checked, that is unreasonable. Diabetes, asthma, heart, all of these things. If you can drive a mile or two miles to your local facility, a routine check-up is much more convenient than some of the things our people are going through.

As has been mentioned, 5 percent of VA funds, which is about $1 billion would be set aside for remote health care. Each VISN receives 5 percent, which is about $53 million. And that would average, if you had 90,000 remote veterans, which I do in my VISN, that would average about $600 per veteran. Now only about one out of every five access health care in a given year, so some of those people would get no help because they wouldn't go. But some people may receive $2,000 or $3,000 worth of care. So that is the way it would be distributed.

Now money which is not allocated in one VISN can be transferred to another. And the other thing that is really important to understand here is that after 3 years, the VA may adjust the percentages. So let's say in VISN–23 we find that 6 or 7 percent of the people really need this type of help. And in VISN–22 maybe only 3 percent do. So it can be adjusted. And we think that is an important component of the bill.

Let me just talk about the advantages. First of all, it is obvious it provides health care more quickly and more conveniently to remote veterans. And currently many of those people simply don't get care at the present time. It would ease the case flows and the wait times at VA hospitals. In other words, if you can divert some of these patients to their local medical facilities, than obviously the overcrowding that already occurs at existing VA facilities is lessened. And we think that is important.

And we think it is also more cost-effective. According to the CARES study, doing outpatient treatment at local clinics in parts

of Nebraska would be one-half as costly as having a VA clinic that would be staffed by VA people, one half.

So we think it would save money. And you realize that many veterans have to pay their own way, traveling a long distance. Sometimes the VA provides the transportation but either way somebody pays for somebody to go 100 miles, 200, 300 miles. If you can go to your local clinic, a mile or two away, obviously all of that expense disappears. So we think that is important.

And then lastly, and I think this is very important, any of you that have rural areas, you realize that rural health care facilities are struggling, some of the small hospitals. And this would divert some money into those facilities that we think might be very helpful to them.

I would like to mention that Arthur Johnsen from Holdrege, Nebraska is here. And Art is a Vietnam vet. And he is the veterans county service officer for Phelps, Harlan, and Franklin Counties in Nebraska. And the counties Art represents are not close to VA facilities but they are not by any means the most remote counties in Nebraska or South Dakota or Wyoming or any place. So it is a pretty typical situation and he will describe those to you.

And, lastly, I would like to thank Dr. Dennis Snook of the Congressional Research Service and my staff member, Kim Miller, for all of the work that they have done here. And we do feel that on the VA side we have some support here. This is not something that is just off the wall, where we are trying to divert monies inappropriately. We think this money will be well spent. We think it will be cost-effective. We would all like more money but given the fact that we have got a certain size pie, I think we have got to divide it up in a way that will be most advantageous to the greatest number of veterans.

And, again, I would emphasize that there are cosponsors here that are from Florida, from New York, and densely populated areas. Every VISN is going to have a fairly large number of remote veterans that are not close to a facility. So we think this addresses that issue.

Thank you, Mr. Chairman. I appreciate your having this hearing.

[The prepared statement of Congressman Osborne appears on p. 84.]

Mr. SIMMONS. Thank you, Tom. Now, Representative Porter, why don't you give your statement, and then we will have some questions.

STATEMENT OF THE HONORABLE JON C. PORTER

Mr. PORTER. Great. Thank you, Mr. Chairman. I appreciate your holding this hearing today and, of course, for your leadership on veterans issues. It is also an honor for me to be here with Coach Osborne from Nebraska who I know has worked so hard for veterans for many, many years.

I grew up in a small community in Iowa, although now I reside and have been in Nevada for 25 years. So I understand the challenges for our veterans in the rural parts of this country. Ensuring access to health care for veterans in rural areas is essential to keeping our promise to the brave men and women who have served our country.

I look forward to the evaluation of H.R. 2379 this afternoon, and I am proud to be a cosponsor of the bill. And, again, look forward to working with you, Mr. Chairman, and Congressman Osborne on its swift passage.

This legislation would greatly improve access to medical services for veterans who reside in rural areas in this country. The same high-quality care must be provided for veterans living in both rural and urban environments. It is our duty to show our appreciation to those who have sacrificed so much for this great Nation.

More than 240,000 veterans reside in my home State of Nevada, one of the fastest growing States in the Union, also one of the fastest growing veterans populations. And I would like to also thank Secretary Principi and the Department of Veterans Affairs for their recent proposal to expand health care services for veterans in southern Nevada. I was excited to join the Secretary in announcing the new VA plan to build a full-service hospital in Las Vegas to help veterans in Nevada.

For many years, veterans in southern Nevada have indicated the importance of such a facility. And I agree with them and have worked towards securing an appropriate facility. Unfortunately, many veterans residing in rural communities in southern Nevada face exceptional hardships from a lack of accessible health care. Nevada being 110,000 square miles, many of these veterans live in the urbanized areas of Las Vegas, Henderson, and Reno. But other veterans prefer to reside in smaller communities and should not be forced to sacrifice their health care benefits.

In my home district in Laughlin, Nevada, patients must drive approximately 200 miles round trip to receive their healthcare services in Las Vegas. During much of the year, high temperatures in the Mojave Desert combined with congested infrastructure make travel difficult and dangerous for older veterans. Approximately 1,400 veterans from the Laughlin area visited the VA Southern Nevada Healthcare System in 2002. This number does not include veterans who forego receiving primary medical care essential for maintaining general good health because of difficult accessibility to VA facilities.

Currently, more than 17,000 veterans reside in the rapidly growing area of Laughlin, Nevada. Increased funding for rural health care would reduce travel difficulties and shorten waiting times for these veterans in need of outpatient health care. While I have illustrated some of the difficulties faced in my home State of Nevada, I am certain the veterans across the United States face similar issues.

Again, I look forward to working closely with the Department of Veterans Affairs and the Secretary, the Honorable Anthony Principi, to ensure that veterans in the rural areas of southern Nevada and across the Nation are provided the best possible health care.

Again, I thank you, Mr. Chairman. I thank Congressman Osborne for bringing this attention to this very important issue and appreciate your fast passage.

[The prepared statement of Congressman Porter appears on p. 88.]

Mr. SIMMONS. Thank you both. I have a comment and a question. I hear numbers such that VISN–23, which is your VISN, Tom, is 93,000 square miles? Is that correct from your statement? VISN–23 serves 90,000 square miles.

Mr. OSBORNE. Yes, right.

Mr. SIMMONS. And in the case of Nevada?

Mr. PORTER. 110,000 square miles.

Mr. SIMMONS. 110,000 square miles. There are five Congressional districts in the State of Connecticut. I represent the second Congressional district. The State of Connecticut is 8,400 square miles. It is hard for us in New England perhaps to comprehend the size of these districts, whether it be a Congressional district or whether it be a VISN.

And the question you raise, obviously, is an important one. Even in my small state of Connecticut veterans will complain that they have got to drive an hour on the interstate, an hour and 15 minutes to get to the VA hospital in West Haven or over to Providence. But the distances that you are talking about are truly extraordinary and the burden it places on somebody who may be sick or disabled or simply not feeling well is a huge burden.

Do you see your proposal, Tom, and do you see this proposal, Jon, as a short-term or an interim solution with some other long-term solution to this problem? How would you characterize this from that standpoint?

Mr. OSBORNE. Well, let me take a shot at that. Mr. Chairman, the way we look at is this would be a step in the right direction. As I mentioned, the percentages I think at some point would need to be adjusted in that we are talking about a 5 percent figure right now. But after a year or 2 or 3 years, it may be that we will find that some of the more densely populated VISNs would not need more than 2 or 3 percent whereas some that are more spacious would need 6 or 7 percent, which we mentioned earlier.

The other thing we have to look at is cost-effectiveness. I think the CARES study was done. For instance, in O'Neill, Nebraska, which is a very small town, they said that to provide outpatient care by the local hospital, it would cost roughly $500,000 a year in that area. If they built a VA facility in Holdrege, Nebraska, same service area, same type of thing, it would cost $1 million to staff it with VA people. So, obviously, there is a cost factor here which I think needs to be looked at. It is not just a matter of time and distance and convenience. It is also a matter of cost.

And so I am not sure this is the final product. But I think the concept can be used to better serve veterans and particularly those who are remotely situated.

Mr. SIMMONS. The second question, Tom, the VA contracts out I believe almost a billion for services that are not provided directly by VA. In your development of this legislation and in your discussions with VA, did they give you any indication that the current contracting system could simply be expanded to address this issue?

Mr. OSBORNE. Well, that is the understanding that we would have, Mr. Chairman. We feel that the current VA system right now really does not encourage contracting. It in every way possible encourages people to funnel patients into the VA system, no matter how far. This would encourage more local care and would provide

some incentives to not continually pile more patients into the existing system, which is already overcrowded. So we think it could serve a dual purpose there.

Mr. SIMMONS. Thank you very much. Now I will defer to my colleague, Mr. Rodriguez.

Mr. RODRIGUEZ. Let me just also reinforce the fact that there is a real need for us to kind of come to grips with it because my district alone goes 240 miles south, and we have some difficulty. But based on the way it would go into effect, my region would lose money the way you have it. In fact, the Nevada area would lose money also because taking that 5 percent across and then re-disbursing it, some of the areas, metropolitan areas would be receiving a lot more and it would be taking away from the area formula that we have had, and that is to distribute the money based in terms on where the veterans are at. So somehow we have got to come to grips with that.

The other concern that I have is that we still need that minimum of the $1.8 billion. If you take this $1.2 billion away, my God, you put us into a more difficult hold. And so somehow we have got to look at the funding aspect of it. There is no way of getting around it because you are addressing the need of 1.6 percent of the veterans with 5 percent of the resources based on your proposal. There is no doubt that somehow we have got to get the service out to the rural. So somehow we have got to come to grips with that.

Let me ask, I guess your perspective would be to try to get providers throughout your region and basically privatize it in that area?

Mr. OSBORNE. Yes, first of all, Mr. Rodriguez, I would like to see more clearly the 1.6 percent that you are talking about being served because we feel it would be larger than that. I am not so sure that your district would lose money. Again, I would like to see that factored in by an accounting firm. But we feel that what we are talking about here is simply letting the local health care facilities provide routine health care.

So rather than having to drive 100 miles, 200 miles to get an insulin shot or to get your diabetes level checked, you can go to your local doctor. And it is not an attempt to take $1 billion out of the system. This is simply re-allocating.

And I realize your desire to have more money. I think everybody here would like to have more money but we are given a certain amount. And what we are saying here is we think we can more efficiently use the money we now have. And so we are trying to save money actually.

Mr. RODRIGUEZ. If that is the case, if you allocate that 5 percent from your own regional money that you already get, in some cases the Nevada area, they would be having more resources to play than based on what you are doing because you are taking away from other regions and displacing it to others.

Mr. OSBORNE. Well, not necessarily. If you will notice that there are people who have cosponsored from Florida, New York, places like this.

Mr. RODRIGUEZ. Yes, New York benefits. The Bronx, Baltimore, and Pennsylvania doesn't. And Kansas does, Denver does, the Long

Beach and Nevada area doesn't. San Francisco doesn't. So there are the winners and the losers.

Mr. OSBORNE. Well, it could be but we are talking about after 3 years that there can be adjustment. This is simply an attempt to get started on the process. As I mentioned, it may be at some point that we will say that there are not as many people remotely situated in VISN–10. So instead of getting 5 percent, they get 3 percent of their allocation. It is not taken away from anybody. They still get the same amount of money but 3 percent instead of 5 percent is allocated for this use.

So we are not trying to take money away from anybody. Every VISN gets the same amount of money. Now if at the end of the year, a VISN has not used their money in this program, they can transfer it to another VISN. But as time goes forward, I am assuming that we will be able to formulate some device whereby the thing would be equalized. And maybe in your committee, through amendment or whatever, you can make a change based on population of remotely situated individuals in each VISN, which would equalize the numbers. I can understand your concern.

Mr. RODRIGUEZ. Yes, and I also like the idea of beginning to address the rural areas but we need to see how we can do that more appropriately. And I would really ask you to help us out with that $1.8 billion that we need now as a minimum. If I were presenting this program, the first thing as a Democrat, they would ask me, "How do you plan to pay for it?" Okay, thank you.

Mr. OSBORNE. It should be no problem.

Mr. SIMMONS. I thank the gentlemen. Ms. Brown-Waite, do you have comments for our distinguished panel?

OPENING STATEMENT OF THE HONORABLE GINNY BROWN-WAITE

Ms. BROWN-WAITE. I would just add that probably a lot of people signed on from States like New York where there are a lot of rural areas that have problems, in upstate New York. Same thing is the case in States such as Florida. There are, believe it or not, not everyone has moved to Florida and had it developed. There are rural areas still in Florida where access is not easily available.

So I believe that that is clearly why people from States other than what people would consider the western States where access is a great distance. There still are areas in those States where access, driving distance still is a problem. I commend you for taking an approach to try to help the veterans.

Mr. OSBORNE. Well, I was surprised in talking to people on the House floor, as I tried to get co-signers, that I would go to people from relatively populist States and they would say, "I have got this problem. As I go through my district, I hear complaints all the time." And I did not assume I would hear that from many people. But it seems to be somewhat of a universal problem across the United States.

Mr. SIMMONS. Mr. Porter?

Mr. PORTER. Thank you, Mr. Chairman. I would like to respond to a couple of comments. Talk about the congressional district that I represent in southern Nevada, in the Laughlin area, as I mentioned there are 17,000 veterans residing in that area. A good

share of those live in Arizona. And there are a lot of these areas that do transfer back and forth.

And our goal, and I am quite sure of the sponsor, is not to reduce funding but to make sure it is spread fairly. There were 1,400 veterans to a facility in southern Nevada, over 200 miles round trip. We want to make sure that it is easy and accessible but not at the cost of other veterans. But to make sure in areas like Laughlin, Nevada where we are sharing two different States, that there is ability to make sure that it is fair, equitable, and that there be resources to take care of these veterans and not to reduce funding but make sure it is spread adequately and fairly.

Mr. SIMMONS. Thank you. Dr. Snyder.

OPENING STATEMENT OF THE HONORABLE VIC SNYDER

Dr. SNYDER. Thank you, Mr. Chairman. Thank you all for your efforts on behalf of veterans. I kind of have a rule in my life that is something is really simple, it probably is really complicated. If something is really complicated, it probably really is complicated, which has slowed me down in life in a lot of things. It seems to me this is really complicated, and I am having trouble sorting it out so maybe you could walk me through this.

So right now we have about $24 billion or so for health care, last year's budget. And your bill, you are going to take 5 percent of that in a reallocation. So we are going to take one-twentieth of that and pull it out. Now is that going to be—how is that being pulled out? Is that just going to be off the top or is that going to be a proportional kind of pull-out from across the country?

Mr. OSBORNE. Each VISN would set aside 5 percent of their allocation, which I believe is about $53 million, something like that. So it would be 5 percent of each VISN's allocation. And I believe each VISN gets an equal amount. You could tell me that, maybe not.

Dr. SNYDER. Well, this is maybe the first complication. The language of the bill, as I read it, "The Secretary shall provide that of the amounts available for any fiscal year for the medical care appropriation for the Department, not less than 5 percent shall be available only for treatment of veterans." It doesn't sound like it is 5 percent done by VISN. As I read it, it sounds like you are taking 5 percent off the top. Is there some other language in here that I am missing?

Mr. OSBORNE. Well, my understanding of the legislation as it was drawn up would be that it would be 5 percent for each VISN. If I am incorrect, maybe somebody here can correct me one way or another.

Dr. SNYDER. Well, let's see, we are going to end of with 5 percent from someplace. And, as I read it, it sounds like it is coming off the top. And I know we all shift priorities around but that money is going to come from someplace. And, as I read this language, it seems, "The Secretary shall provide," 5 percent is going to come, as I read it, off the top. Five percent of their budget is going to come from someplace to put into what is a very worthy goal I think is care of veterans.

Mr. OSBORNE. It is a reallocation of resources, yes.

Dr. SNYDER. One person's reallocation is another person's cut. So then this first year they are going to have this money and it is

going to be just distributed evenly. Is it going to be equally divided between the VISNs or equally divided on a population basis?

Mr. OSBORNE. My understanding it is being divided equally among VISNs.

Dr. SNYDER. Among the VISNs regardless of the population within those VISNs?

Mr. OSBORNE. That is my understanding, yes. And it may be, as I mentioned earlier, Mr. Snyder, that some population allocation would be more equitable. I am not saying that this is the final version that needs to come out of this.

Dr. SNYDER. This section (e) on the last page says, "The Secretary may provide for a lesser driving time in the case of any veteran if the veteran determines that a driving time of 60 minutes or greater poses a hardship on such veteran or otherwise in the best interest of the veteran. Knowing that we set things in statute and once they are set in statute, they generally stay there for several years, if not decades, if a decade from now we had an administration whose goal was to really privatize the VA system and shut down the structure we have now of the VA network throughout the country, as I read that language, the Secretary could just say, "I am now going to declare 20 minutes," "We think for a 72 year old veteran greater than 25 minutes or 30 minutes, that they will be able to get all their care provided for maybe privately." Is this language maybe broader needs to be for what you are trying to achieve?

Mr. OSBORNE. Well, it may be the committee feels that way. As I mentioned, in my testimony, maybe some of you have driven through West Virginia and you realize there is just one range after another and so some guy may be 30 miles away but it is going to take him an hour and half to two hours to do that 30 miles.

Dr. SNYDER. Yes, I understood that. But this language sounds like if the driving time, "The Secretary may provide for a lesser driving time."

Mr. OSBORNE. Right.

Dr. SNYDER. So am I correct they could say 30 minutes drive time?

Mr. OSBORNE. Right, it is at the discretion of the——

Dr. SNYDER. Of the Secretary.

Mr. OSBORNE. Of the Secretary.

Dr. SNYDER. Yes, yes.

Mr. OSBORNE. I am assuming that if there was someone who was critically ill and they said this person, there is no way they can even tolerate an hour's drive, that we can make this exception. So it may be overly broad as far as the committee is concerned. But I just wanted you to know that that is how we wrote it because we felt that we would like to give some discretion. And assuming that people are people of good will and they are attempting to do the right thing by the patient.

Dr. SNYDER. Thank you. Thanks to both of you for your concern for veterans. I think in emergency situations, the staff can answer, the Secretary already has that authority, do they not? They can go to any hospital, right.

Mr. SIMMONS. Under emergency situations, yes. The gentleman from Arizona?

Mr. RENZI. No questions.

Mr. SIMMONS. Mr. Strickland?

Mr. STRICKLAND. Thank you, Mr. Chairman. I serve an Appalachian district. My district is in Ohio, which I think many people consider a fairly well developed State but my district stretches for over 330 miles from end to end. And it is very small town, don't find interstates or many in my district. I guess the question I have is the definition of a VA medical care facility because I do have some VA clinics. Would a clinic be determined to be the measure that we would use in terms of driving time? What kind of facilities are you thinking of when you are talking about accessibility to a VA?

Mr. OSBORNE. We are talking about a VA facility which would include clinics.

Mr. STRICKLAND. My only concern with the legislation, quite frankly, would be if it would mean that people who live, veterans who live in my region would get less as a result when I know—we all know the resources are stretched. And I would just like to make reference to something you said earlier. You said we would all like more money but we are given a certain amount. And I would just like to point out, as I think we have on this committee many, many times, that certain amount does not come from the Almighty. It is something that we determine right here in the Congress.

And so if I determine that I can support your legislation without doing harm to the veterans that I am charged to represent, I certainly will support that. But I think I need to think through that because I am not sure how we can do what you are suggesting without there being less resources for those who do not live in these highly rural areas. I have always considered my district a rural area but I don't know that it would meet the definition necessarily of the highly rural area that is referred to in the bill.

But, as Dr. Snyder has said, I deeply appreciate the fact that you, as we all do, hear from our veterans and their difficulty getting access and the travel times and the fact that many are quite sick and it is really difficult. So I think your motivation is as pure as the driven snow. I just am not sure what the full implications of that may be for all the veterans elsewhere. So thank you.

Mr. SIMMONS. If I might make one comment as Chairman. We certainly are not locked into this, if somebody wants to apportion the monies based on the percentage of veterans in a VISN that would be considered geographically remote. So in other words, you say in VISN–23, there are 90,000 veterans. In VISN–10, there are only 50,000. I am certainly not suggesting we shift money from one VISN to another. That is not the objective.

Dr. SNYDER. I think that is a very helpful suggestion, sir. Thank you so much.

Mr. SIMMONS. Mr. Porter?

Mr. PORTER. Thank you, Mr. Chairman. I would concur with my colleague from Nebraska. The intent was not to take funds from one area and give to another. But I would also make it clear that I do not and will not support privatization of veterans' services and benefits. But there are unique times and situations where we should give the Secretary the ability to make adjustments to fit the

needs of rural America. But the intent is not to privatize in any shape or form the delivery other than under unique circumstances where there are no other options in a rural part of America.

Mr. SIMMONS. I appreciate both of those comments. It seems like we are moving in the right direction. And that is why these hearings are so useful.

Mr. Boozman?

Mr. BOOZMAN. I don't have a question, I just have a comment. Again, I know both of you well, and I appreciate you so much for thinking about some of these issues that confront our veterans. I know that you like all of the members on the committee on both sides here that work together so well for them. Like I said, I just appreciate your taking the time to try and come up with some creative ideas to solve some of these very difficult problems.

Mr. SIMMONS. According to our procedure, I will now recognize Mr. Rodriguez for a second time unless he wishes to pass. Mr. Baker?

OPENING STATEMENT OF HON. RICHARD H. BAKER

Mr. BAKER. Thank you, Mr. Chairman. Congressman, I appreciate the effort to facilitate access to those constrained to rural environs and unable to get a reasonable driving time to a VA facility as well as Mr. Brown-Waite's proposal later to be discussed relative to overall waiting time.

But it frankly seems to go at the more basic underlying question. If we are going to provide care for veterans, we are establishing triggers where the basic system has failed in order to provide assurance that there is a second level of care, either because of distance, lack of access, or delay in treatment time. And I don't expect necessarily a comment. But it seems to me, at least in my home state, we have a lot of privately-owned hospitals with a lot of vacant beds who are having trouble making it in the competitive medical marketplace. And we have veterans driving through my city, sometimes 90 miles away, to get to New Orleans to get care in facilities that are very old and understaffed with long waiting lines.

I fully support your effort, but I think we probably ought to examine maybe going further. There ought not—if the goal is care for veterans, and we have places that can provide competent care, we ought to see they get it when they need it and figure out how to do that in an efficient manner. And I am not all together convinced that the current delivery system is the most efficient in the world and, more importantly, nor the most compassionate.

So I am for whatever we can do to make it work better. And if this is the first step, I am willing to be right there with you.

Thank you, Mr. Chairman.

Mr. SIMMONS. Thank you. Mr. Snyder for the second time. Okay, Mr. Murphy?

Mr. MURPHY. No questions.

Mr. SIMMONS. Thank you. Hearing no further questions, I want to thank the members of the panel for their presentation. And I want to thank them for observing that rural veterans, because of their geographic location, probably get less benefit from the VA than veterans located in other areas. And that inequity must be ad-

dressed. And I thank you for bringing that to our attention. Thank you.

The second panel involves two veterans who have made the journey to Washington, DC to testify before the Subcommittee. The first is Arthur L. Johnsen, a Veterans' Service Officer from Franklin County, Nebraska. And the second is Mr. John J. Kenney, a Veterans' Service Officer from Citrus County, Florida. And it is my understanding that my colleague, Ms. Brown-Waite, knows Mr. Kenney and would like to say some flattering things about him, which is fine by me. But I would ask if anyone objects to giving Ms. Brown-Waite that time, as long as they are flattering things? Hearing no objection, I recognize Ms. Brown-Waite.

Ms. BROWN-WAITE. Thank you, Mr. Chairman and members. It would be very hard not to say flattering things about J.J. Kenney. Before I even came to Congress as a State senator, my office very often called on him and he was always there and always very, very supportive and helpful to veterans and on veterans' issues. J.J., as he is fondly known as, served 22 years, 9 months, and 2 days in the Marine Corps. He retired in September 1986. And I am sure he counted all the way down to those last 2 days. He served two tours in Vietnam flying as a gunner on resupply and Medivac choppers. He is a disabled veteran as a result of one too many helicopter crashes and one very exciting parachute jump, which I am sure he will be happy to tell you all about later.

After he retired from the Marine Corps, he spent several years working in other positions. And then he left them, and we were fortunate to have him move to Citrus County in Florida. He joined the Citrus County veterans' service officer as the assistant county service officer and then he was very quickly promoted to the position as county service officer. Actually he runs such a good shop that in 2002, the VFW of the United States Department of Florida VFW selected his office as the service office of the year.

He is a life member of the VFW and the Navy's Aviation Boatswains Mate Association. Other memberships include the Military Officers' Association, Fleet Reserve Association, Marine Corps League, Navy CB Veterans of America, Citrus County Veterans Ad Hoc Committee. And I could go on and on. He is very involved in the community in Citrus County.

He and his wife have been married for 38 years. They have three sons and six grandchildren. Mr. Kenney and his wife I am fortunate to claim as constituents. And they reside in Homasassa, FL.

Mr. Chairman, I believe that he is here to speak on my bill, and I didn't know if you wanted me to briefly describe my bill first or what the procedure you would like to have happen.

Mr. SIMMONS. Is there any objection to Ms. Brown-Waite describing her bill from the dais? Hearing none, please proceed.

Ms. BROWN-WAITE. Thank you very much. For those of you who were at the last hearing, I apologize for not being here. Believe me, I would have much rather have been here than in Bethesda Naval Hospital having my arm re-set, which, thank to clumsiness, I broke. The good news is great medical care there.

I certainly want to thank the chairman for the opportunity to discuss the bill, which we then had to reintroduce. We introduced

it with the support of several members of this committee on September 16.

Nationally, we have over 59,000 veterans who have enrolled in the VA's Health Care System and cannot be seen at their preferred site within 6 months. And they are placed on a waiting list. In Florida, there is a backlog of over 12,000 veterans seeking VA medical care. I know I hear daily from my constituents, as do other Members of Congress, about the long waiting care. Amazingly, this number is actually down from the number of veterans waiting longer than 6 months just 1 year ago. There is no doubt this is a testament to the very hard work of Secretary Principi and Under Secretary Roswell. And I certainly applaud their efforts. However, the current situation is still very unacceptable.

As a Members of Congress serving on the Veterans' Affairs Committee, we all have a duty to those who fought and served our country. We must fix this problem. Codifying the VA's own access standards for primary care services is a means by which we can accomplish this goal.

On February 11, Secretary Principi and his deputy, Leo McKay, came before this very committee and testified that VA has the funds necessary to eliminate wait times. While progress has been made, the fact that nearly 60,000 veterans are still waiting longer than 6 months means that there are 60,000 men and women who served our country who are actually being under served now by their government.

The Presidential Task Force makes it clear in its report that, "Providing sufficient funding to the VA will not by itself guarantee timely access to primary care or even specialty care appointments." Mr. Chairman and members, VA is the second largest federal agency. It is appropriated billions of dollars a year to provide health care to our veterans. However, it is consistently cited by the GAO as an occupant of its high-risk list for fraud, waste, and abuse. Clearly, there is room for improvement here.

This legislation requires the Secretary to provide for outside primary care, a primary care physician to see the veteran at the VA's expense if the veteran cannot be seen within the proscribed access standard of 30 days. A veteran, of course, may elect to wait for a longer period of time. This provision in the bill does not apply to geographic service areas that are rated at 90 percent compliance or greater. The primary care limitation is necessary because of cost variables and also a desire to develop an effective solution to address veterans' needs.

Mr. Chairman, codifying the VA's own self-imposed 30 day access standard for primary care appointments is not about the VA. And it is really not about funding. And it is not about Congress. It is really about the veterans and it is about accountability. I think that failure to take action is the equivalent of turning our backs back on a problem that we know exists. We should not lose the opportunity to bring accountability to the VA. I think that the stakes are too high.

I agree with Mr. Rodriguez that the standards—that as protectors of the public funds, we need to be concerned about unintended consequences. I, however, would propose that the unintended consequences of not holding the VA's feet to the fire is that there will

be more and more people whose health is put in jeopardy. I know of at least one woman whose husband waited in excess of 18 months to finally see a VA doctor. By the time he saw the VA doctor, that cancer had spread throughout his body. He was riddled with cancer. Needless to say, he died very shortly after that first primary care visit. How much better his health care would have been if he had gotten to see a primary care physician and then even had the option, he was Medicare, had the option if he couldn't get in to see a VA oncologist that fast, he would have had the option to go to a Medicare physician. But he couldn't even get in for the first appointment. That is the unintended consequence that I don't want on my conscience.

Thank you, Mr. Chairman.

Mr. SIMMONS. Thank you. And we have two witnesses. Do you gentlemen have a preference as to who speaks first?

Mr. KENNEY. I will defer to the gentleman on my right.

Mr. SIMMONS. Well, that is very kind of you. You got such a glowing, flattering introduction. The very least we can do for Mr. Johnsen is let him go first. We have two bills before the Subcommittee, and I invite your testimony, both, one or the other.

STATEMENTS OF ARTHUR L. JOHNSEN, FRANKLIN COUNTY VETERANS SERVICE OFFICER, NEBRASKA; AND JOHN J. KENNEY, CITRUS COUNTY VETERANS SERVICE OFFICER, FLORIDA

STATEMENT OF ARTHUR L. JOHNSEN

Mr. JOHNSEN. Thank you, Mr. Chairman. Before I begin, I would like to thank the chairman and the committee for the honor of being able to come here and testify. I would also like to thank and commend each committee member for his service to our veterans. From what I have heard here today, I am very pleased and impressed and thank you, ladies and gentlemen.

I will begin my testimony by informing the committee of the distance my veterans have to travel. I live in Holdrege, Nebraska and that is 90 miles from the Grand Island VA Medical Center. It is 100 miles from the North Platte Community-Based Outpatient Clinic. We are 225 miles from the Omaha VA Hospital, which is the closest VA hospital. It took me four hours to drive to Omaha to catch the plane that took me two hours to get to Washington. That is the travel issues.

There are other barriers to our veterans receiving health care, which have been mentioned in the past. We have our inclement weather, winter and summer. And I believe the summer is more dangerous to our elderly veterans. They are World War II and Korean veterans traveling with their wives in temperatures in excess of 100 degrees on the interstate or our secondary highway systems. We also have another growing group of veterans that are the veterans that cannot drive due to their age, infirmity, disability, whatever and their health care is resting with their children or family friends to get them to the VA hospital, which doesn't happen most of the time. They miss appointments. Their prescriptions run out and they fail to get there.

My question is what is going to happen to the ever-increasing number of veterans that have no family members and that are facing health care issues. Or when they are ill and they have to travel 200 miles when they are sick or ill, what happens to those veterans?

The other issue that I would like to address is timeliness. And I believe the timeliness issue can be broken down into two different categories, timeliness of appointments and timeliness of care. On the timeliness of appointments, my office we are running about 5 months for an initial visit for a veteran that is newly enrolled in VA health care. And those are for service-connected veterans also. If we get a new rating and we apply an enrolled veteran, it is going to take him 5 months to get the appointment. Secretary Principi has a 30 day time line for the Priority 1 group veterans, those that are service-connected, 50 percent or greater. And I believe the Grand Island VAMAC is doing an excellent job at that. They are seeing the Priority 1 veterans.

This brings us to the second part of our timeliness issue, which is the timeliness of care. I have had veterans waiting 5 months for services that would take 2 days in a private physician's hospital to find out whether they had cancer or not. I have had veterans wait 6 weeks after they have had a heart attack waiting for open heart surgery in Minneapolis because they were told they weren't an emergency and couldn't be handled at the University of Nebraska Medical Center.

I would also like to address how rural veterans are being considered by the Capital Asset Realignment for Enhanced Services, the CARES incentive. I was approached to serve on the CARES CAMP team for the Grand Island VA Medical Center team. I was told that one of the primary functions was to improve primary access for all veterans. Our plans included improvements to the Grand Island VA Medical Center and to open four community-based outpatient clinics in the State of Nebraska along with expand some already existing clinics and existing contracts. We did submit that to the CARES Commission. The CARES Commission released a draft plan and, to my shock and disbelief, the Nebraska clinics were pushed down to Priority 2. In other words, we might be considered for these clinics in 2007 or after.

As the CAMP team was to learn the reason that the State of Nebraska, the States of North Dakota and South Dakota were told that they weren't getting much was due to the total population. I don't believe that was right. There was many of us on the CARES CAMP team that pointed this out from the beginning, that the process is punishing the rural States and we never would qualify for favorable recommendation from the CARES Commission.

Also, I am pleased to inform the committee that I have received very few complaints about the quality of VA health care. In fact, quite to the contrary. I receive many compliments. I think that is due to a change in VISN–23. And I have also witnessed a change in the attitude of VA employees toward the veterans. I think I see an attitude of greater respect. And I owe this change to VISN–23 director, Dr. Robert Petzel. He is doing a fantastic job for our veterans in that VISN.

In closing, I thank the subcommittee on health for their time and urge them to strongly support H.R. 2379 introduced by the Honorable Ginny Brown-Waite. Thank you, ladies and gentlemen.

[The prepared statement of Mr. Johnsen appears on p. 90.]

Mr. SIMMONS. I thank the gentleman. We now recognize John Kenney. And, as you have noticed, there is a green light, yellow light, and red light. Keep an eye on those lights. Thank you, Mr. Kenney. Please proceed.

STATEMENT OF JOHN J. KENNEY

Mr. KENNEY. Good afternoon, Mr. Chairman and members of the subcommittee. I would like to thank the chairman and Congresswoman Ginny Brown-Waite for the opportunity to come before this subcommittee to provide testimony on the issue of timely access to VA healthcare. This is by far one of the most important issues our veteran population, and particularly our aging World War II and Korean veterans face. This is a national problem. But as a veterans' service officer in the State of Florida, the State with the second largest veteran population, and I believe the oldest veteran population, the problem of access to health care is acute.

Please allow me to provide the subcommittee with some background on the plight of Florida veterans from the vantage point I have as a veterans' service officer in Citrus County. Here we have a veterans population of over 24,000. Prior to the year 2000, we had no VA primary care available in Citrus County. Fortunate veterans were able to travel 45 minutes to Ocala to receive care. However, the majority would travel north about an hour and a half to Gainesville to seek primary care. And even a smaller number would travel south over two hours to either Tampa VA Medical Center or Bay Pines. The majority of these men and women are elderly, having served their nation, like I said, in World War II and Korea. Many had to rely on friends and family and fellow veterans to meet their travel needs.

To our great relief, the VA opened the community-based outpatient clinic in Inverness, Florida in July of 2000. A mass enrollment was conducted and everyone, myself included, was shocked by the overwhelming numbers. Remarking on this, one of the VA staffers commented, "Build it and they will come." They came, in large numbers. In addition to these mass enrollments, our office processed 17,068 applications for health care as of the 26th of September this year. Almost immediately after opening the doors at the clinic in Inverness, veterans were told it would be over a year from the time of enrollment to the time they would get their first primary care appointment. If a veteran had an immediate problem, he or she was instructed to drive to Gainesville, be seen at urgent care where they would be seen for that specific illness or injury but not be assigned primary care.

The patient load at our Inverness clinic as of the 25th of September 2003 is 3,948. Care for nearly 4,000 veterans is spread between three doctors with an average patient load of 13,016. With regard to the wait times, veterans that are rated 50 percent service-connected or higher are being seen within the 30 days per the direction of the Secretary. Veterans rated zero to 40 are being scheduled within 90 days. Non-service-connected veterans with ur-

gent medical care needs receive their appointments within 1 week to 90 days. Non-service-connected veterans without any major medical problems can look forward to up to 180 days without receiving their first primary care appointment.

With the exception of service-connected veterans rated at 50 percent or higher, these wait times are unacceptable. A delay in health care between 90 and 100 days would be unacceptable for every member of this committee. And it is just unacceptable to tell a veteran this is the best you can do.

When I received my invitation to appear before this subcommittee, I had members of our veterans' service team conduct a random review of enrollment forms that we held in our office. We covered the period January 2001 to June 2003. The longest wait time was 33 months for a primary care appointment, the shortest, 1 month. We found several veterans who had sought care in 2001. And other than receiving their letter acknowledging they had been accepted into the health care system, they had not be scheduled. Once we notified the clinic of this disparity, they are now tentatively scheduled to be seen some time in November. I believe Congresswoman Brown-Waite's staffer has a copy of our review that we did conduct to come up with those numbers.

I know this is not part of the issue, but I think the subcommittee should be made aware of the some of the wait times too as far as specialty clinics are concerned. In Gainesville, we have a backlog of about 25,040 just in audiology. Staffing continues to be a problem, getting permanent staff members. Our clinic is almost like a mobile pool. We have a couple of contract doctors in there now.

By approving this bill, three important things are going to happen. First and foremost, you are going to ensure that those who have served this great Nation receive the type and quality of care they deserve.

Second, you are showing those who are currently serving in the United States Armed Forces, as well as future Marines, sailors, soldiers, airmen, and Coast Guard. And we as a nation are mindful and grateful for the sacrifices made by the men and women of the Armed Forces.

Third and finally, I believe it will make the Department of Veterans Affairs more efficient. No organization wants to pay for services that they are capable of delivering themselves.

I believe the VA is currently making significant strides through the CARES program, and I applaud the Secretary's accomplishments in this area. VA will better serve those men and women who honorably serve this Nation by clearly identifying the areas of need, the realignment of assets to meet the demand. This legislation will enable the Department of Veterans Affairs to accomplish the mission a grateful Nation charged them with, to provide timely and adequate health care to our veterans. H.R. 3094 in my opinion is a good piece of legislation, and I believe it will positively contribute to the improvement of the VA Health Care System.

Mr. Chairman, members of the subcommittee, I thank you for the opportunity to come forward and speak to such a distinguished group of gentlemen and ladies as you are such. Thank you.

[The prepared statement of Mr. Kenney appears on p. 94.]

Mr. SIMMONS. Thank you for your testimony and thank you for coming up here to Washington, DC to provide this testimony.

Mr. Johnsen, on page 3 of your testimony you refer to Secretary Principi's 30-day time line for veterans who are 50 percent service-connected or higher. And you indicate that it appears that the VA is meeting that guideline or that time line at least for Category 1 or Priority Group 1 veterans. In your experience, when a Priority 1, Category 1 veteran shows up, is any effort made to equate the seriousness of that veteran's health care need or condition with that of a veteran of another priority, assuming that the two of them show up on the same day?

Mr. JOHNSEN. No, the service-connected veteran gets the priority. And as far as the seriousness of the health issues, I don't believe from my experience that that has been taken into account.

Mr. SIMMONS. And you, Mr. Kenney, have you observed that issue or not?

Mr. KENNEY. With our 50 percent or higher veterans, we are getting them in under the time frame. We also, if we find a veteran that has a real serious medical need, they are making room for them. The servers, the providers, the VA care providers that we have in our VISN, I can't say enough about the providers. They are doing a great job. It is not the VA I saw when I was a kid when I used to go down to the VA hospital with my pop. These people, they care about the people that they are working for. They are sincere and they are dedicated. And no one should ever say anything derogatory about the staffers providing medical care for VA.

Mr. SIMMONS. So this is the good news/bad news. Great care once you get in. But it is damn hard to get in. That is the problem.

Mr. KENNEY. Exactly, yes, sir.

Mr. SIMMONS. Okay, I appreciate your testimony. Mr. Rodriguez?

Mr. RODRIGUEZ. Let me thank you first of all also for your testimony. I think some of it, I think it is relative also. As I recall, there are a great number of complaints and there is no doubt that the VA needs to improve on the quality and those waiting lists are just not appropriate. But, as I was sharing with the chairman, the private sector, and if you are not in the VA and you are just in the private sector out there, it is tough. So relatively now the VA is looking a lot better just because the whole system is collapsing in front of us.

Let me ask you regarding to responding to the need, I think the only problem that I have is how do we provide those resources out there because of the fact there are some areas, we almost have—and tell me if I am wrong, how in some of those areas we almost have to look at privatizing, is that true?

Mr. JOHNSEN. Well, I would not think so. I think contracting would be the way to go. Privatizing, like my colleague I am not here to say anything derogatory about the VA. It isn't the VA that it used to be back in the 1970's and 1980's. There is quality health care available in the VA. They are doing an excellent job there. How to fix it to where we can all get access to it, now whether that would be through contracting, maybe use formulas like they do somehow on Champ VA through fee services, the VISN, through contracting of the VA itself. The VA has many options I believe they can use for remedying that situation as far as how do we get

the health care delivered to the veteran. I said the option that the Champ VA has right now. It could be not that but a similar program to that, sir.

Mr. RODRIGUEZ. Because I was just going to add that the privatizing aspect of Medicare that we tried has not worked for rural America. And in fact it has cost us more than the straight Medicare, the one we used to always complain about and yet that has been more cost-effective than privatized Medicare that we have come up with. So somehow we have got to address that, and we have got to meet that need. And I wholeheartedly agree with the issue of accountability. But I really don't feel that we are providing the additional resources that are needed to meet that need. And I think that is where we vary and disagree on.

I wanted to ask in some of those areas whether you think it would be more appropriate to hire some additional doctors or a mobile unit that would go into rural America versus doing a clinic?

Mr. JOHNSEN. We have had traveling what they call VA vans out in our rural area before. They were just basically a mini-clinic. You could get blood pressure taken, flu shots, things like that at the appropriate time of year. I believe there has to be some type of fixed site facility, and I know with the CARES Committee are not trying to get into owning bricks and mortar again but maybe leases, CBOC's, contracts with the local doctors, but there needs to be something that is accessible, especially if the veteran needs a service that would be like a two-day service. We have had veterans waiting 5 months to find out if they had cancer or not that could be done in a two-day time frame. I think our veterans should be scheduled in that time frame just to prevent the incidences that the lady was talking about of another veteran dying of cancer just due to a waiting period.

Mr. RODRIGUEZ. One of the other realities, just like with the mail, it has never been cost-effective in rural America. It never has and the private sector is never going to want it because of that. Very similar is the health care is something that we have to subsidize to a degree because it is not going to be accessible and profitable. And so somehow we have got to look at that. And I yield to the rest of the members. Thank you.

Mr. SIMMONS. I thank the gentleman. Ms. Brown-Waite?

Ms. BROWN-WAITE. I would just have a quick question for Mr. Kenney. Tell me what happens to the veteran who goes, for example, to Gainesville for urgent care? I have had some constituents tell me what happens but I don't know if you have had any complaints about what happens there?

Mr. KENNEY. Well, the first problem is getting them there. Fortunately, I carry about a $15,000 portion of my budget for bus transportation. I alternate Wednesdays and Thursdays with a bus with wheelchair capability. And last year we were augmented by the DAV. So we have transportation 4 days a week. But there are restrictions on the transportation because they have to be back in the county by a certain time. Normally, a veteran will go up, check in urgent care, and it for the most part can turn into an all day affair. And we have in fact had the transportation leave on several occasions. When I was the assistant veterans' service officer, I was told to go to Gainesville and pick them up. So it is a long process. But,

once again, I want to reiterate, once they are seen, the quality of care is outstanding.

Ms. BROWN-WAITE. I think every member of this panel who serves in an area where veterans have to wait, everybody agrees on that, that once they get into the system. But, again, it is the same thing of health care delayed is health care denied.

Mr. KENNEY. Yes, ma'am.

Ms. BROWN-WAITE. Thank you.

Mr. SIMMONS. Mr. Snyder?

Dr. SNYDER. Thank you, Mr. Chairman. Mr. Kenney, just one question. I know you came in support of Ms. Brown-Waite's bill, the preceding bill, Mr. Osborne's bill, under the language that it is written, I think your VISN will lose money in the reallocation in the first year, which is like mine in Arkansas, which I am all for finding more efficient ways of doing things. But when you have a formula that right off the bat in kind of it seems haphazard way just pulls money out of our system which already needs additional funding, I am not sure that it is the best way to go.

Mr. Johnsen, in your written statement you made a comment a conversation with a group of doctors, I think.

Mr. JOHNSEN. Yes.

Dr. SNYDER. I haven't practiced medicine for a while but I was a family doctor before doing this. And under the language of Ms. Brown-Waite's bill, the reimbursement that is set in this bill it will be Medicare rates except that there will be no co-pay. I don't know about you but the doctors I talk to right now, they are containing their enthusiasm about Medicare rates. They are not lining up to say, "Oh, please, Oh, please, give us more patients paying no more than Medicare pays without the co-pay." I think it is going to be a hard sell.

I think the biggest concern I have about Ms. Brown-Waite's bill is, number one, putting in the statute a standard, the 30 day standard, which makes it very difficult to deal with. But I think the statement was made that this is not about funding, it is about not turning your backs on veterans. Well, to me it is about funding. And somehow I just don't see how—something is going to give. We know we already have veterans hospitals that are having difficulty meeting this standard, they are failing, which right away means they are going to have to find money to pay for care in the private sector, which I guess we could print more money. We are pretty good about doing that around here in these last few months. But I think that is not what we are about, which means that that money has got to come from somewhere. I assume it will come from the health care services being provided in the system that is already there. And I just don't see how this is going to help.

The chairman of this committee, Mr. Smith, is in strong agreement that we are shorting the system by $1.8 billion. Well, the cost—I think this bill has been modified since you brought it before so I don't think we have a recent CBO study, but I assume it is somewhere in the $1.5 to $2 billion range, I assume when CBO costs it out. It is difficult to understand how pulling more money out of the system is going to help deal with a shortfall that I think all the veterans advocates believe is there already.

It is a similar kind of problem in Mr. Osborne's bill. We say, "Well, it is not a cut, it is just a reallocation." Well, if you are the veteran who has somehow been reallocated, it feels like a cut to you. So I think these bills are well-intentioned but in my view are I think going to have great difficulty being signed into law because ultimately they are going to aggravate a problem that we already think is there, which is that the system is under-funded.

Now if somebody is an advocate and really wants to shut down the veterans' health care system or gradually and dramatically move to a privatized system, then this is certainly a route to go. And I can understand why some may feel that we and do feel that way. But for those of us that think the VA system is a distinct system in which veterans will best be helped if we support it adequately, I don't think either one of these bills is the way to go. It is going to make it more complicated for the people trying to provide care with funding that is currently inadequate. I think this committee, I think unanimously has acknowledged that the budget is $1.8 billion short or in that range.

I don't have any questions for you. I hope though that this Congress will be very cautious about moving ahead in something that pulls money out from the system that we have already said I think that we believe should have more dollars in it. Thank you for your testimony here today.

Mr. SIMMONS. Thank you. Mr. Renzi?

Mr. RENZI. Thank you, Mr. Chairman. I want to focus on what I think is the underlying causation, and I want to say thank you to the Congresswoman from Florida. Mr. Kenney, if you look at the fact that you have got a veteran out there who let's say has a life-threatening, deteriorating condition. And that veteran is not able to get into the system. Congresswoman Brown-Waite's legislation provides that family who is faced with a life-threatening illness, a life-threatening disease, a safety valve. Do you agree?

Mr. KENNEY. Yes, sir, I do.

Mr. RENZI. And we heard stories coming out of Florida, compassionate stories about people whose cancer has gotten worst. Since day one, since I have been on this committee, I certainly don't have the experience of some of the colleagues here, but I have heard time and time again how people can't get the initial appointment, can't get the follow-up appointment. And yet again now this is a reasonable safety valve for that family who is suffering with the not only threat of cancer but the threat of being denied timely care. Do you agree?

Mr. KENNEY. Yes, sir.

Mr. RENZI. And we have got the obligation to provide that care in a timely manner to our veterans. So I think now we boiled down to that we have all established the fact that we are $1.8 billion short. It is interesting to hear my colleague on the other side discuss the matter when we had 59 Republicans vote against the VA/HUD. And yet at what point do we say the cost is what we are really focused on versus the deteriorating condition? In other words, at what cost do we tell that person, "No, you have got to get back in line," or, "No, we don't have the time for you yet." And if it is real, and these stories of life-threatening cancers and dete-

riorating conditions are true, then the cost really isn't a factor. Do you agree?

Mr. KENNEY. Yes, sir.

Mr. RENZI. Any comments?

Mr. KENNEY. As far as funding is concerned, sir, and I am not the duty expert on funding or anything else but there seems to me to be three areas where funding could be attractive for VA health care. I believe right now the Medicare Subvention program, they are doing some test sites there. We are losing millions and millions of dollars in VA budget treating Medicare-eligible patients that the VA is unable to bill for. All they are getting is that $7 co-payment for the medications and the $15 for a primary visit or the $50 for a specialty. We are doing the same thing with our Tricare people, our Medicare—our Tricare military retirees. They are not able to bill them. That is a source of income.

And, second, I would say—thirdly, I am sorry, I would say an average of 35 to 40 percent of my veterans are enrolled in VA health care for the pharmaceutical benefit. I know we are doing if they are in it for 30 days, then the Secretary has allowed them to honor civilian prescriptions, for those people who are waiting over 30 days. It always comes up, well, we are worried about the liability if we honor a civilian prescription, things of that nature. For as long as I have been associated with DOD, they have been honoring civilian prescriptions.

Mr. RENZI. It is a safety valve.

Mr. KENNEY. Yes, sir. If we get these people—if we would honor that, the medication—this would go away because the assets the VA has could be directed towards direct patient care. More people would be able to get that primary care that want it.

Mr. RENZI. Thank you, sir. Do you time to respond, Mr. Snyder? I yield time.

Mr. SIMMONS. I thank the gentleman. Mr. Strickland?

Mr. RENZI. Mr. Chairman?

Mr. SIMMONS. Oh, excuse me.

Mr. RENZI. I am yielding time to my colleague.

Mr. SIMMONS. I misunderstood.

Mr. RENZI. I am sorry.

Mr. SIMMONS. Without objection, Ms. Brown-Waite.

Ms. BROWN-WAITE. Thank you very much. Dr. Snyder, I am sorry that he left because I did want to respond to him. He asked if this was a route to privatizing health care. I believe it is a route to accountability because if we don't act to make changes, the VA, if we don't hold some people's feet to the fire, the VA will continue to be on the watch list. There will continue to be fraud, waste, and abuse. And who is suffering from it? Certainly not the VA bureaucracy but the veteran who is not getting timely access to health care.

This, ladies and gentlemen, is all about accountability. The President's Task Force said that they can do it. Mr. Principi said that they can reduce those wait times. And I believe they are working on it. But until Congress says you have to do this, our job in this committee is to set policy. Let the appropriators find the money. And there are so many of the members on this committee who are fighting to get that $1.8 billion restored. I had predicted that the

people who voted for the VA budget, when they went home, that they would be barraged by veterans.

And I believe they are because we now have a lot of converts, don't we, Mr. Renzi? People who are now joining us in the fight to get that money restored. I serve on the Budget Committee, and we had that money in the budget. It is about mandating accountability. It is about saying to the veteran who has had this promise from the VA since 1985, that is when the first—I am sorry, 1995 is when the first promise was made that they would have access within 30 days. It is about keeping a promise that VA made to them.

Thank you. Thank you, Mr. Renzi, for yielding. Thank you, Mr. Chairman.

Mr. SIMMONS. Thank you. Mr. Strickland?

Mr. STRICKLAND. Mr. Chairman, we need to have an honest conversation in this committee and in this room. Mr. Johnsen has indicated that people were waiting 5 months for an initial visit. There is not a Member of the House or the Senate that would tolerate that. All of us, everyone of us should be ashamed of ourselves. But, Mr. Renzi and Representative Brown-Waite have mentioned those who voted against the VA/HUD bill. Everyone of us know that the critical vote in terms of restoring the needed funding was not the final vote on the bill. There were 59 Republicans that voted against the final passage of that bill. But there were only six Republicans, and our chairman was one of them, that voted against the rule. And the rule would have allowed us to have added the $1.8 billion to that bill that we need.

Now we are operating under some false assumptions. The assumption is that we should punish the VA for this problem. The problem is not the VA providers. The problem is this Congress. We are the ones who need to have our feet held to the fire. If we don't talk honestly about this, it does no good for us to even be here. The problem is a funding problem.

We need to do two things. The first thing we need to do is to provide adequate funding. Now after we have done that, if the VA falls short, if the VA doesn't perform as they should, we need to hold them accountable. And we will do that by firing people or contracting out or whatever we have got to do to get services to veterans in a timely manner. But we need to be honest with each other. There is a money problem that this VA system faces. And until we solve that problem, it does no good to talk about helping some veterans through a contracting out process when that simply will result in the taking of money from these facilities that are already without sufficient resources and using it for private contracting out.

I agree with everything Dr. Snyder said. I think he made a lot of sense. We shouldn't rob Peter to pay Paul in this process. We should provide sufficient funding. And then if the VA falls short, hold the VA accountable. But I just think it is unfair for us to hold the VA accountable for something that is our responsibility to start with.

Thank you, Mr. Chairman.

Mr. SIMMONS. I thank the gentleman.

Mr. RODRIGUEZ. Will the gentleman yield?

Mr. STRICKLAND. If I have any time, I will yield to my friend.

Mr. RODRIGUEZ. Thank you very much. I know the debate usually comes back and forth in terms of accountability and funding. But I want to thank you clearing that because we did have an opportunity to go before the Rules Committee to try to get that 1.8. And I know that there was an effort in terms of—and I know that the chairman here was there with me. And there was a little game played by both, some Democrats on the House floor on the rule and the Republicans on the rule. And the actual vote, if you want to look in terms of was the motion on the rule that disavowed the opportunity to have that $1.8 billion brought up there. And I want to thank—I also want to thank the chairman for being there with me at 11:30 or 12:00 midnight before the committee, trying to that $1.8.

That 1.8 is still not sufficient to go beyond, it is barely to take care of existing services. We have got to understand that, that, yes, on accountability issues, but our veterans are reaching that age where they need us now. Those numbers are blooming. And so as we pump in more money, yes, we have been pumping in more money, we still need more because those numbers are growing. So disproportionately——

Mr. STRICKLAND. Will my friend yield back the time?

Mr. RODRIGUEZ. Yes, I will.

Mr. STRICKLAND. I want to point out the $1.8 million isn't a sufficient amount because, as you recall, in the President's budget, he calculated that he would have certain increases in prescription drug costs, certain increases in enrollment fees for certain veterans. And they calculated how much the VA would save by the numbers of veterans that wouldn't participate as a result and the income the VA would get as a result of those increased charges to veterans. This Congress says that is not going to happen, but we haven't supplanted that money, we haven't added the money that is being lost as a result of those additional things being made a part of the budget. So $1.8 billion is not a sufficient number. There are millions beyond that that we are going to fall short if this Congress doesn't act in an appropriate manner.

I yield back.

Mr. SIMMONS. I thank both gentlemen for their comments. For those of you in the audience, it has been an interesting few months, and I suspect it will continue to be interesting. The Chair recognizes Mr. Boozman. No comments. The Chair recognizes Mr. Baker. Pass. Mr. Murphy?

Mr. MURPHY. Thank you, Mr. Chairman. A few things in my reviewing this. I wanted to ask when you talk about support for this legislation, which I think has got great intentions, I also call attention to something in the 2001 GAO report which suggests problems of poor scheduling procedures, inefficient use of staff, perhaps other errors that go with that too. And also I think a 2000 report also said there were some problems there as well. And I know that we all feel that there is excellent care at these facilities. But I have worked in hospitals. And I have worked with some of the finest physicians, nurses, and staff in the world, but I have also worked with people who are clueless with modernizing what they are doing.

And I look at some of the things here in this bill, and I wondered about a couple of things here. For example, periodic reviews I think are an essential part and I think we need to demand those and get that information. I might say too that I am concerned that it does a global generalization of all delays. It doesn't break them down by clinic, for example, by dental clinic or vision clinic or internal medicine or other aspects. And I suspect there are various things here too.

But I also look upon this when I think of some of the comments you made and previous ones made too about distances people have to travel. And when people are traveling, yes, indeed that saves them some cost if they go locally. I wonder if we are going to see a couple of things happen here. I think, Mr. Kenney, you mentioned a 30 to 40 percent of the numbers are people who are seeking pharmaceutical?

Mr. KENNEY. Yes, sir.

Mr. MURPHY. Which obviously threw the numbers way up, which obviously overwhelmed that couldn't handle those kinds of things——

Mr. KENNEY. Yes, sir.

Mr. MURPHY (continuing). Nationwide and that is a big part of why we see this. And I am hoping that as we deal with Medicare prescription drug issues, we can reduce those. But I too have to say I am concerned that if we go this route, what we will be doing is spending more money in the direction of getting care for people. And I want to see them get quick care.

But some concerns here. It this a matter though that if it is problems of the staff understanding modernization and better use and efficiency with scheduling, taking more money away isn't going to fix that. If it is an issue of not enough physicians, not enough building space, not enough nurses, taking away money isn't going to fix that. It is going to take away more from what has already been pointed out by my colleagues about not enough money in the VA health budget. So I get concerned about that.

So my comments back, Mr. Chairman, are also that I wonder about moving in a direction of being punitive. And I wonder also in a direction that should we be thinking of other ways of getting the Department, after having had a number of years to try and work on fixing this problem, tell us some other routes that they are going to do about this or get rid of some people. Because I see this as also some human factors here in services, Mr. Strickland talked about do you out-source and get someone else to come up with a better scheduling procedure on here as well? Do we review and see what kind of other staff are needed? But to only go the route of taking funding away by having people go somewhere else I am not sure is it. The winners in this will be those who get faster access.

And I think we all want to see that. And I think that is the intent of this that I like. The losers will be we take more money away from a system that I think is already hemorrhaging. And that is where I worry about this. I would hope that part of what comes out of this, and looking forward to the testimony, is much more pressure by this committee in saying this VA has got to fix this problem. It is serious, it is deadly, as Ms. Brown-Waite has

pointed out. It is tragic. But I worry that just taking more money out of this isn't going to work.

Mr. SIMMONS. I thank the gentleman for his comments. At this point, I would like to thank the panel for their presentations.

Mr. BOOZMAN. Mr. Chairman, I know I passed. Could I ask just a very short?

Mr. SIMMONS. Absolutely.

Mr. BOOZMAN. Mr. Johnsen——

Mr. SIMMONS. Without objection.

Mr. BOOZMAN (continuing). He mentioned 30 or 40 percent, are you saying the same numbers in that or higher?

Mr. JOHNSEN. Well, to the best of my knowledge and from what I am familiar with dealing with, our situations are somewhat different. We live in—I live in rural Nebraska and our incomes are quite a bit lower than the national average. A lot of my veterans do not even have Medicare because it costs them and they can't afford it with their social security. So I am sure the numbers have inflated because of the prescription, but how much I couldn't put a percentage on it.

I would like to follow up by saying that what you all are doing here is important. The veterans' groups in my county come together to furnish me the trip to Washington, DC and they expect a report back. And I am happy to report that I will tell them that people in Washington, DC do care about what is happening in rural America. And I thank you very much.

Mr. SIMMONS. I thank the gentleman and I thank the two witnesses. Thank you very much for coming and helping us out as we address these issues.

My colleague, Mr. Rodriguez, has an item that he would like to submit for the record. Why don't we call our third panel, Dr. Robert Roswell, Under Secretary for Health. If he would assume the chair. And I now recognize Mr. Rodriguez.

Mr. RODRIGUEZ. Thank you. I wanted to submit a letter from Beth Moten from the American Federation of Government Employees, representing some 600,000 federal employees, as well as 140,000 employees in the Department of Veterans Affairs regarding H.R. 3094. I would like to submit her letter for the record.

Mr. SIMMONS. Without objection, so ordered.

[The letter follows:]

AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO

John Gage
National President

Jim Davis
National Secretary-Treasurer

Andrea E. Brooks
National Vice President for
Women and Fair Practices

8b/132024

September 30, 2003

The Honorable Chris Smith
Chairman, House Veterans Affairs Committee
335 Cannon House Office Building
Washington, DC 20515

The Honorable Lane Evans
Ranking Member, House Veterans Affairs Committee
334 Cannon House Office Building
Washington, DC 20515

Dear Chairman Smith and Ranking Member Evans:

On behalf of the American Federation of Government Employees, AFL-CIO (AFGE) and the 600,000 federal and DC government workers we represent, including 140,000 employees at the Department of Veterans (VA), we wish to raise our concerns regarding H.R. 3094.

Veterans' lack of access to health care is a dire symptom of a larger failure to commit adequate staff and financial resources to provide care for the men and women who have served our nation. Inadequate staffing levels and lack of the resources needed for staff to deliver high quality care coupled with the legitimate increase in demand for veterans' health care has created the harmful and unacceptable explosion of waiting lists.

The access standards in HR 3094 without sufficient funding or sufficient staffing levels are standards in name only. The VA needs adequate obligatory funding that keeps pace with the escalating cost of medical care inflation and the VA needs to maintain firm safe staffing levels in order to meet any access standards.

A significant and detrimental consequence to H.R. 3094's approach to ensuring access to care is to shift medical services and veteran patients from the VA to the private sector. Facilities which have the most disparate mismatch between funding and staffing levels and demand by veterans for health care will be the

most vulnerable to being forced to fund privatized veterans' health care. In such facilities, veterans will have a 30-day wait for a voucher to go to the private sector. Such a shift in services to the private sector will consume that facility's already deficient funding and erode its ability to maintain specialized services programs. Without adequate funding and increased staffing levels, the enforcement mechanisms of H.R. 3094 will trigger the unraveling of the VA as a unique health care system and result in the promotion of a voucher-like system for privatized veterans' health care.

The VA is a national asset and providing veterans with health care is a responsibility which rests with the government – not the private sector. Efforts to shift patients to non-VA providers can set a dangerous precedent, encouraging those who would like to see the VA privatized and the federal government turning its back on its promises to the men and women who have served. Access standards are important, but they will only be achieved by first providing the VA with sufficient funding and safe staffing levels.

Given the significant and adverse, albeit unintended, consequences of H.R. 3094, we urge you not to approve this bill as drafted.

Sincerely,

Beth Moten
Legislative and Political Action Director

Mr. SIMMONS. Dr. Roswell, welcome. You have listened with great interest and intent to the proceedings. You are familiar with the two bills before us in this hearing, and we look forward to your testimony.

STATEMENT OF ROBERT H. ROSWELL, UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS

Dr. ROSWELL. Well, thank you, Mr. Chairman. It is a pleasure to be here. Mr. Rodriguez and members, it is a distinct honor, as always, to appear before you. And I also join other witnesses in recognizing your leadership in addressing what is a significant need.

I am pleased to be here this afternoon to present the Administration's view on the two bills we have been discussing, H.R. 2379 and H.R. 3094. The sponsors of these bills have introduced the measures in an effort to improve access to VA health care, a goal which I certainly embrace. One that VA has aggressively addressed over the last several years.

Interestingly, the two bills address access in two different manners, one, geographic access, the other, timely access. Ironically, as has been pointed out by members here today, without additional resources, the two bills actually would serve to aggravate the very situation the other bill addresses by pulling scarce resources away from our current operations. Therefore, we believe that both bills would actually be harmful to existing efforts to improve access overall. And, consequently, we oppose both measures.

In our view, H.R. 3094 has the potential for dramatically increasing demand for VA care. The bill does not differentiate between an initial primary care appointment and a follow-up appointment, which may be scheduled based on the provider's judgment. The bill makes no allowance for clinical appropriateness or need for a primary care appointment within 30 days. And it fails to recognize that urgent care is already available to any veteran who may need it on a same day basis nationwide.

At this point, we don't believe any of our VISNs would be able to comply with the 30 day standard required by the bill. Consequently, if the bill were enacted, every VA facility would be forced to offer veterans desiring a primary care visit the opportunity to receive that care through a contract with private sector providers. This would be extremely costly and would rob scarce resources from our efforts to increase our primary care capacity.

Further, care would be fragmented between non-VA and VA providers with no assurance that vital clinical information would be captured in our electronic medical records system, a records system that I would point out as the single most important factor for enhancing the quality of VA health care that this committee has heard about today.

In recent years, we have faced unprecedented new demand for services. We have been unable to provide all enrolled veterans with services in a timely manner, and we have been forced to place many veterans on waiting lists. Nonetheless, we are making significant progress in reducing waits for veterans desiring appointments. Just over a year ago, as pointed out, we had over 300,000 veterans waiting 6 months or more for an appointment. Today, this number is 60,000. And, in fact, only half of that number, approxi-

mately 30,000, are waiting for their initial appointment for VA care.

We have concerns that enactment of H.R. 3094 has the potential to seriously disrupt the progress we have made in reducing waiting lists.

I next turn to H.R. 2379. As you know, Mr. Chairman, VA has developed a very sophisticated methodology for allocating appropriated funds in the fairest way possible. H.R. 2379 would be disruptive to that VERA system and would be unfair to veterans in many parts of the country where currently available medical care funds would be significantly reduced as a result of its requirements. Within the last few years, two separate external reviews of the VERA model were conducted to ensure equitable allocation to both rural and urban areas. The first was conducted by VA work groups and was based on AMA systems reporting evaluating rural health care. The second review is the Rand Corporation's Phase 3 VERA study. Neither review found that an adjustment in VERA model was needed to account for rural health care.

We also have serious concerns that the bill would result in significantly increasing our non-VA health care expenditures by essentially forcing VA to increase the number of veterans receiving such care. Often such care is much more expensive than VA furnishes directly, as was pointed out. I would also point out that VA already has authority to provide many veterans with non-VA care at VA expense due to geographic inaccessibility to VA care. In using that authority, VA takes into account the individual veteran's needs and ability to access VA care.

Finally, as you know, we are now in the process of carrying out a major health care planning process known as CARES. The draft CARES national plan incorporates exacting and precise access criteria developed through the application of state-of-the-art methodology and data. These criteria have enabled VA to address and develop a cost-effective investment strategy to improve access and ensure the availability of acute care infrastructure, as well as rural access to care.

Enactment of H.R. 2379 could seriously disrupt the months of planning and analysis already invested in the CARES' process. By forcing reconsideration and revisions to the market plans of the 21 VISNs, it could result in an unacceptable delay in the Secretary's final decision.

Mr. Chairman, I apologize for the length of my remarks. A more detailed statement, of course, has been submitted for the record. And I would be very pleased to try to address any questions you or the committee members may have.

[The prepared statement of Dr. Roswell appears on p. 97.]

Mr. SIMMONS. Thank you very much. Does the addition or subtraction of $1.8 billion to the 2004 budget make any difference in your assessment of these two bills?

Dr. ROSWELL. Well, certainly additional resources would be very welcome by the Department because ultimately, as has been pointed out repeatedly, that is the issue here. But my answer would be, no, it does not make any difference. The reason being that the access standards create an inequitable platform across the Nation. It would create a differential access to care based on the region on the

country. Ultimately, the resources must be I believe directed to enhance the VA capacity to provide care and to capture all of that care through our computerized patient records system.

Mr. SIMMONS. Mr. Kenney suggested that the presence of these bills and bills like them might provide an incentive to the Veterans Administration to improve access to care for the rural population and to those who are encountering long waiting lists. Are you incentivized by the idea that some Members of the Subcommittee are attempting to legislate solutions to these problems?

Dr. ROSWELL. Well, there is a broad range of issues already codified in the regulations that are based on legislation passed by the Congress and its predecessors that regulate how VA provides access to care. And we are diligent in our efforts to abide by those regulations. The Veterans Eligibility Reform Act identifies that the Secretary must provide a uniform national health care benefit for all enrolled veterans. A uniform national benefit in many regards may be inconsistent with the provisions of both bills presented before this committee this afternoon.

Mr. SIMMONS. We talk about a uniform national benefit, and we talk about some veterans, who because of their priority, get faster access and other veterans because of their geography get better access. Is that fair?

Dr. ROSWELL. No.

Mr. SIMMONS. And these bills propose doing something about that.

Dr. ROSWELL. They do. I appreciate the fact that the bills are an attempt to address equitable access. Ultimately, though, as you yourself have pointed out, I believe it is an issue of resources. And to try to preferentially solve one issue without addressing it in the context of the entire issue I think has some fundamental pitfalls that we need to be very cautious about.

Mr. SIMMONS. Thank you very much. Mr. Rodriguez?

Mr. RODRIGUEZ. That sounds a little familiar from the private sector trying to serve rural America also where it actually becomes more costly to them and they are better off staying in the urban areas. Just like delivering the mail, it is just more cost-effective in an urban area where they are real close by versus in a rural area. And so it almost would force us to have to subsidize, which means I would presume that it would cost us a lot more per patient than in the urban area. Is that a safe assumption?

Dr. ROSWELL. Well, actually, the VERA methodology analysis shows that rural care is less costly to provide than urban care. However, very rural care, again these are not just arbitrary definitions but I cannot quote the exact precise definition, is in fact more costly. So fundamentally you are correct, that in very rural areas there may need to be some types of subsidy. Usually though very rural areas are associated with rural areas where the care is less costly.

Mr. RODRIGUEZ. But in the case of a chronic, say you are beginning to provide that service and there is a real need for chronic illness, what is a scenario for surgery and those kind of things that have to be brought in to where they are accessible? You tell me.

Dr. ROSWELL. It is very difficult. Contracting for care in rural areas may not be the best solution either. It may be that the best

solution is to move veterans to where we have excellence in surgical care. A group known as the "Leapfrog Group," a non-governmental group, I might add, has actually suggested that surgical care in this Nation might be better provided if it were limited to only approximately 100 centers of excellence.

We have taken a great deal of effort to develop a surgical quality program, the National Surgical Quality Improvement Program, that provides the accountability of our surgical outcomes. But increasingly we have seen that smaller surgical facilities may not be able to maintain the level of surgical proficiency. And that is reflected in the CARES national proposals that I forwarded to the CARES Commission earlier this year. We have those same concerns when we are forced to contract for surgical care in rural communities, that purchasing care in a small rural surgical facility for a veteran may not afford the best quality of care.

So there are some fundamental problems that we in the Department have to address and we as a Nation have to address with health care.

Mr. SIMMONS. Ms. Brown-Waite?

Ms. BROWN-WAITE. Thank you, Dr. Roswell, for being here today. First of all, I have a basic question. My office attempted to contact your office several times last week to discuss the bill and to discuss any concerns that you have. We did not get a return call. Is this normal up here in Washington, DC? I am new here so I need to ask that question. Is this kind of disrespect and ignoring of the sponsor of bill normal and then you come and submit your testimony? I haven't had this experience with any other agency so I need to know if this is standard operating procedure with VA?

Dr. ROSWELL. It is certainly not. I would be pleased to take any call from any member of your staff at (202) 273–5781.

Ms. BROWN-WAITE. They have tried, sir. The lady is sitting right back here. She tried several times.

Dr. ROSWELL. I never received the message.

Ms. BROWN-WAITE. And never got a return call from you.

Dr. ROSWELL. I will certainly speak to my secretary.

Ms. BROWN-WAITE. From your legislative people to find out if there were any concerns that you all have.

Mr. BAKER. Ms. Brown-Waite?

Ms. BROWN-WAITE. I don't think any member up here would appreciate being sabotaged and not hearing back from an agency at all. But let me go on.

Mr. BAKER. Ms. Brown-Waite, I think you are on a waiting list. (Laughter.)

Ms. BROWN-WAITE. That is not encouraging to know. Your comment that this bill has the potential to dramatically increase the demand for VA health care and overwhelm the ability to provide service, I think that you are already denying health care. And will this increase? I am not sure. But let me ask another question. Is the strategy of VA to just continue to the same-old, same-old and have access to care times lengthy so that veterans don't get care. Is that what the goal has been historically? Remember I am new here, okay.

Dr. ROSWELL. I appreciate the concern and I certainly would hope that you would call my office directly, not our Office of Con-

gressional and Legislative Affairs if you have trouble getting through because I will, I promise you return your calls.

With regard to what VA is doing. Let me point out that in 1995 VA operated a system of hospitals. We have added 677 community-based outpatient clinics, including the ones in your district since 1995. During that time we have more than doubled the number of veterans who are enrolled in our system. In fact, the enrolled number of veterans has gone from fewer than 3 million to almost 6.9 million. The resources have increased by 34 percent during that same time period within our medical care appropriation. We do need to continue to expand access to the VA health care system, but I think it needs to be done with careful planning and with sufficient resources to assure quality outcomes.

Ms. BROWN-WAITE. A follow-up question, Mr. Chairman. Then why does the VA hold out a false promise since 1995 of we want to serve you within 30 days? I think that is disingenuous at best. And when you have areas of the country where people are waiting, where their health is being impaired because of that wait, I think that we would be remiss if we didn't act on that.

And let me ask one other thing. Isn't it the job of the Secretary to request appropriate amounts of money to serve the veterans, sir? Because if the appropriations bill that passed is back to what the Secretary asked for, then, (a) he did not ask for enough and that $1.8 billion, if that is all that he believed that he needed, then this $1.8 billion should be a windfall or somebody over there has a calculator that simply doesn't work.

Dr. ROSWELL. Thank you. Let me the promise, as you call it. The 30–30–20 goal was never a promise. It was a stretch goal recognizing that timely access to care is hard for us to obtain. It was never a statutory requirement. It was never a departmental rule. It was never a promise to veterans. It was simply a goal to provide care for patients enrolled in primary care within 30 days and to have veterans wait no more than 20 minutes.

Let me point out that nationwide, through our performance management system, since 1995, we have attained that goal in virtually all VISNs for patients currently enrolled in primary care. Where were fail to obtain that goal is for those veterans who have not yet been enrolled in primary care. And, again, that is where the tremendous growth has been that wasn't unanticipated when that goal was articulated in 1995.

Part of our effort to preserve the quality for the veterans who currently receive care is to preserve a high access to care because that is critical to the outcomes.

Ms. BROWN-WAITE. Would you support the bill if it only applied to those currently in the system? Or is it the goal to just keep things same-old, same-old?

Dr. ROSWELL. We are striving for continuous improvement but let me point out that of the 6.9 million veterans currently enrolled, there are approximately 2 million who have not used the system. If we were to, if this committee were to pass legislation that created a significant perceived enhancement to VA health care benefits without commensurate resources, even to those currently enrolled, it could create a phenomenon of moving people from the en-

rolled non-using population into the enrolled using population and create another serious situation for resources.

And, finally, let me address the Secretary's request for resources, if I may. The Secretary's request for resources I think recognizes our plan to expand the system and continue to expand access. But let me point out that the Secretary also operates under a statutory requirement that requires him to examine on an annual basis the availability of those resources and then determine the level of enrollment. And he is charged to carry out and has carried out that statutory requirement.

Mr. SIMMONS. The Chair recognizes Mr. Strickland.

Mr. STRICKLAND. Mr. Chairman, I want to thank you for this hearing. I think it has been very helpful. And although I don't, at least at the present time, support either of these bills, I think the discussion has been very helpful because I think it has caused us to think about some things that we need to be thinking about.

Doctor, I am going to ask you a question and the answer is self-evident, I think. But I want to ask it just to get you on the record. Are you opposed to waste, fraud and abuse in the VA system?

Dr. ROSWELL. Yes, I am.

Mr. STRICKLAND. Now a follow-up question. Would you be more motivated to get rid of waste, fraud and abuse as a result of the threat posed to your financial resources by either of these bills? Or are you already as committed to getting rid of waste, fraud and abuse as you possibly can be?

Dr. ROSWELL. I would say the latter.

Mr. STRICKLAND. I assume that to be the case and that is why—and I think my question, although may seem facetious, I think it is relevant because I don't think that we should pursue either of these bills as a way to put pressure on the VA to do something that I think the VA is already trying to do under current circumstances. I don't think there is anyone responsible for leadership of the VA who is not concerned about waste, fraud and abuse and who is not committed to getting rid of it. And so I think that is just a given. I just don't think that is a legitimate or a valid motivation for either of these bills.

Doctor, you have testified previously that the VA needs, I think you have said between 13 and 14 percent bump annually just to keep pace with current requirements. Now all of us on this committee have been trying to push for additional funds and so we will just accept that. But in the event that that doesn't happen, in your view, are the problems that we are discussing here today, access, timely access, whether because of geography or just because of numbers, are those problems largely a resource issue in your mind or in your judgment?

Dr. ROSWELL. They are very directly a resource issue. Let me point out though that my over-arching goal and philosophy is to provide veterans with high-quality care. And in our enthusiasm to make VA care accessible, which I applaud, we must be cautious to make sure that we don't provide ready access to lower quality care or care that ultimately doesn't serve the needs of our veterans.

That is why I believe that the available medical care appropriation needs to be used to build capacity within the VA health care system, addressing all of the goals we have talked about, access,

timely care, quality care. But we need to build a VA capacity. And then the Secretary, if the demand—and I don't believe that the authorizers or the appropriators in this Congress, as tremendous a body as it is, can accurately, universally always predict what the demand for care will be. That is why the Secretary has that statutory authority to look at the demand for care, to look at the availability of resources, and exercise an enrollment decision.

But to me that is how we need to evolve the VA health care system. We don't need to fragment it. We don't need to piecemeal it. We don't need to partition it out into community providers where we are less certain about the quality care. We don't need fragmentation across the system. We have worked with the Presidential Task Force to try to have a seamless health record. We are making tremendous progress so that a veteran's health record begins at the time of initial enlistment and moves with him lifelong, seamlessly. And I believe that that same sort of seamlessness needs to be in the care we provide to America's veterans.

Mr. STRICKLAND. Thank you, sir. I appreciate your testimony. And thank you, Mr. Chairman.

Mr. SIMMONS. Thank you. Mr. Renzi?

Mr. RENZI. Thank you, Mr. Chairman. I think it is somewhat of a misconstrued assumption to think that the motivation behind this bill is one to pressure the VA. I think our colleague's from Florida motivation, as established in her opening comments, is to find ways to better care for and deliver timely access to our veterans, particularly in some of the extreme cases that we heard as far as deteriorating conditions are concerned. The gentleman spoke about honest, I don't think that assumption even——

Mr. STRICKLAND. Will my colleague yield?

Mr. RENZI. No, I will not.

Mr. STRICKLAND. Will my colleague yield?

Mr. RENZI. I don't think that the causation in writing this bill has anything to do with pressuring you one way or another or to get involved in waste, fraud and abuse. I think it is trying to find a way to really take on and solve what is a really tough issue in many of our districts. In my district, some of the Navaho people I have heard before have to hitchhike four hours and then they get there and some of the appointments have been cancelled.

You spoke about the reduction of waiting time and you cited some statistics, which sound interesting. Can you give me the primary reason why the waiting times have gone down and where you are going with the future of how you will reduce the remaining?

Dr. ROSWELL. I would be happy to. We have created performance measures. We use the supplemental appropriation last year to specifically address this. And in certain cases we actually contracted for care to catch up with the backlog. We have identified individual access coordinators for each of the 21 VISNs. And with a national work group we are addressing what we call Advance Clinic Access Initiatives. Essentially what we are doing is building capacity within the availability of resources by extending clinic hours, by increasing provider panel size, by making care more accessible. Then we have also used resources this year to actually significantly increase the number of providers, both physicians and mid-level providers, physician assistants, and nurses.

Mr. RENZI. I applaud the increase in the physicians. One of the things that I think you can teach me, and I may be wrong on, is if we have an individual who is in a critical condition or a deteriorating condition and they are not able to, again we are hearing the stories, access, veterans care, you spoke about urgent care, could you help me understand that, please?

Dr. ROSWELL. Urgent care is available on the same day basis in any of our hospitals. What I was saying was that any of our medical centers, 163 nationwide, that operate urgent care areas will provide that care on a same day basis for anyone who needs such care. The problem is that we now have over 1,300 locations of care, most of which have actually only opened in the last 6 or 7 years. And a community-based outpatient clinic that has very limited capability and no urgent care or emergent care capability, is not situated or able to provide urgent care.

Mr. RENZI. That is correct.

Dr. ROSWELL. Therefore people are re-directed to those medical centers where urgent care is available. With the action of this Congress, we actually have an emergency care benefit that a veteran can avail himself of to seek care in a non-VA provider. So there are a number of ways that people have access to urgent or emergent care.

Mr. RENZI. In my district, which is over 60,000 square miles, the Prescott Hospital is the only place that I have that has urgent care. So if I have a veteran who walks in with a real deteriorating condition into a clinic and then is re-directed to Prescott, I am looking at sometimes driving times six or seven hours. And I am looking at a waiting list there typically because it is my only urgent care facility that I can get them to. And so, again, you can see the frustration on this side. And certainly, and while I applaud the numbers that you have talked about, the idea is a veteran and his wife, who stood by him during the war, is now suffering with the idea that unless they can get that vet to a doctor, the cancer is going to spread, the disease is going to spread.

And we are talking about money here. And the gentleman talked honestly, there absolutely isn't enough money. Absolute fact. No one disagrees with it. We can disagree whether it is the rule or whether it was the underlying bill. But it is under-funded and we have got guys who are in deteriorating conditions because we are not getting to them. Something has got to be done. And I again want to thank you for making it a real good bill in my belief come to light.

Thank you, Mr. Chairman.

Mr. SIMMONS. I thank the gentleman. Mr. Rodriguez has indicated he is going to pass. And so we go to Mr. Boozman.

Mr. BOOZMAN. You mentioned earlier that this services have doubled since 1995. What do you attribute that to?

Dr. ROSWELL. There are a number of factors. I believe that VA has significantly addressed the quality and accessibility of its care, as well as the patient safety and patient satisfaction with which we provide that care. I believe that the eligibility reform legislation, which became effective on October 1st of 1998, and made a full uniform health care benefit to potentially all 25 million veterans is another major factor. And the third factor, the third of a series of

many factors, but the third major factor would be the general state of the economy and the fact that more and more veterans are reaching the age of Medicare eligibility where they don't have access to third party insurance benefits and are increasingly finding that Medicare lacks a critical prescription drug benefit that in today's health care marketplace is a much greater component of the care we provide than it was in 1963 when Medicare came into being.

Mr. BOOZMAN. He mentioned the I think 40 percent range or whatever, I have heard figures here that it is closer to 50 percent, the figures I have heard you all state.

Dr. ROSWELL. In fairness, the 50 percent figure is based on surveys of veterans using VA for the first time. If you look at the veterans who have been enrolled in VA and have been receiving care in their VA, it is a much lower number. But for brand new first time users, yes, it does sometimes run as high as 50 percent.

Mr. BOOZMAN. I guess I am very, very sympathetic to the 30 day thing. Again, I think though that we have got to address the underlying cause as to where we get there. One of the concerns I have is that the criteria of the physician not being able to charge the co-pay, I just don't think that is going to happen. I am an optometrist. Dr. Snyder is a family practitioner. And right now we have—it is very difficult to get—it is becoming very difficult to get Medicare providers to see patients. They are backing off on the amount that they have seen.

A big problem in our area is Tricare in the sense that really just a handful for the whole VISN will accept new patients. And the reason for that is they pay a little bit less than the Medicare allowable. But when you are talking about 20 percent less, then I think the danger, almost like the danger here that we have of saying we have got this 30 day rule, I think we lay false hope. The other problem is then you make the physician the villains and they are not the villains. Medicare is having the same problem that we are having in the sense that actuarially they are as unsound as anything that we face in Congress. And because of that, they are really rationing things down.

Like I say, they are just not going to do it. That is going to create I think a whole different set of problems is having to deal with the physicians as to why they can't do it. And so again I think we almost run the risk of that false hope.

Ms. BROWN-WAITE. Mr. Chairman, if Mr. Boozman would yield?

Mr. BOOZMAN. Yes, ma'am.

Mr. SIMMONS. Do you yield time?

Mr. BOOZMAN. Yes.

Ms. BROWN-WAITE. I just wanted to let you know that we are working on a manager's amendment dealing with the Medicare issue, making sure that they are Medicare-licensed and we certainly will address the issue of the 20 percent co-pay because I think that I agree with you, that was one of the things that was missing in the first draft of the bill and we are working on a manager's amendment.

Thank you.

Mr. SIMMONS. Does the gentleman yield back?

Mr. BOOZMAN. Yes.

Mr. SIMMONS. Mr. Rodriguez, do you have any comments you wish to make?

Mr. RODRIGUEZ. Along side with the fact that we have had an increase in growth, we still have a large number, what is it, close to 2 million that are not being seen, veterans?

Dr. ROSWELL. There are 2 million enrolled who are not currently using the system.

Mr. RODRIGUEZ. As the system gets worse outside, everything is relative. All of the sudden the VA becomes more attractive since what we have out there in the private sector is terrible. I am talking about the difficulty, I am trying to get to a dentist in the last 2½ years and I haven't been able to. I think we are just going to see a lot more difficulty unless we begin to address some of the problems that exist out there and we have been unwilling to do that. And that goes for all of us. We have been playing games and not addressing the needs, especially with prescription drug coverage. And so it is going to keep piling up for us. And we have a good opportunity next time to really talk about it during the election coming up.

Mr. SIMMONS. Mr. Baker?

Mr. BAKER. Thank you, Mr. Chairman. Unlike Ms. Brown-Waite, I am not new. I have been here a pretty good while. And I have read a lot of testimony. And I have got to tell you this is unique written testimony. Your oral presentation was decidedly better. But what I read here is troublesome to me.

Let me start by observing that the bill does two things, the 30-day standard and establishing a minimum wait time for a patient to be able to be seen. When you read through the language, it says that you shall determine the wait time, not some arbitrary, out of the sky, dropped on the agency without consultation pursuant to your own field examination of current practices. When you are unable to meet your own 90 percent performance standard, of the standard you have established pursuant to your own review, then things happen. Well, that leads you to conclude, at the bottom of page 2, "It will overwhelm our ability to provide care in VA-operated facilities."

I would pose to you, sir, that last year when the Secretary asked this Congress to fund VA health care needs, this Congress responded by over-funding that request by $1.1 billion. And concurrent with that request being over funded, was a commitment by the Secretary to eliminate the wait list according to the VFW's director's testimony here to be presented later. Today, there are 100,000 veterans waiting 6 months or more and up to 2 years for specialty care, which contradicts your numbers of 60,000. I don't know who is correct. Either one is unacceptable.

You say you are not able "to provide compliance with the 30-day standard for 90 percent of the patients seeking primary care during the first quarter of 2004 should this requirement become obligatory. Thus, every VA facility would be forced to offer veterans desiring a primary care visit the opportunity to receive care on a contractual basis." Let me understand it. I can't get care at the VA facility so I am going to give you the opportunity to go somewhere else. That is a horrible thing. Someone might get help somewhere else. But you do not come in with the suggestion, only the proposal

that they might get inferior care. You do not suggest higher copays, other constructive criticisms to make the bill work. You simply say it is an unworkable thesis.

"We would anticipate," again on page 3, second to the last paragraph, "We anticipate the increased amount for primary care generated by the measure would dramatically increase demand for specialty care." I guess just because it is out there, people would go see a specialist. Or is it the other point, that there are people waiting in line, needing specialty care who can't now get it so they would avail themselves of a private opportunity? Maybe that is the conclusion we should draw.

Page 4, second paragraph, "It does not take into account patient convenience or agreement." Now let's see, we are worried that you might have to wait longer than 30 days to see a doctor, that if you are in the office and we set up our own self-determined wait time, let's say eight hours, you can't see the person within eight hours, and we are suggesting you might go somewhere else? I am at a loss to understand how that conclusion is reached.

It goes on to say we have an apparent "standard for the length of time a veteran would have to wait to see a provider on the day the appointment is scheduled, requiring contracting for care when we are unable to substantially comply." The rationale for this is unclear to us." Let me make it clear. We don't want people showing up on the day of their appointment and having their appointment cancelled without notice. I get angry calls from veterans all the time. It does happen and it is still happening. We don't want people to sit in the waiting room for five hours for a five-minute exam. That is not professionalism. Translate numbers.

What would you do in your office if someone showed up for a previously arranged appointment at 10 a.m. and you said, "Oh, I will be happy to see you at 4:30." Now would that be a happy constituent? Worse yet, you don't give them prior notice. They show up for the appointment for the Congressman, "I am sorry, we have to cancel. Can we reschedule that for say 6 months from now?" Do we wonder why people have frustration.

We go on. "It is also not clear how the day of service standard would or could be implemented or satisfactorily monitored." This is a system which we are asking the agency to construct, supervise and implement. Are we suggesting that you don't have the ability to construct a managerial system which can conduct patient flow? I suggest just the physicians on this panel could probably help you with management of patients flow.

"We have established strategic goals to achieve the level of timeliness indicated in the bill." That is on page 5. After all the complaints about the inability or impossibility of achieving what Ms. Brown-Waite is suggesting in the bill, you conclude to us that you have strategic goals to meet the same levels of timeliness as indicated in the bill? That just is very troubling. Go back to the original comment as to the facts, which Mr. Strickland, who unfortunately has left, was wanting to indicate were important to the base of our discussion. Last, 2003, the committee, the Congress, $1.1 billion above the administration's budget request with the concurrent commitment to eliminate the wait list. We now have dispute as to how big the wait list is, whether it is 60,000 or 100,000.

But there is a wait list. That is not in question. I am looking for strategic recommendations, ways to enhance health care delivery, not just an abject refusal to acknowledge that the private sector might have a few people who could help those in dire need be seen and receive appropriate levels of professional care. And as to the private contracting, you, sir, the agency, would set the criteria by which a private practice would be admitted into the VA system. We would suggest you send somebody out to a check cashing center to get leg surgery. You would dictate the criteria by which those individuals would be allowed to have referral rights.

I am frustrated, Mr. Chairman. I apologize for going on. The gentleman certainly has a right to respond, but I don't believe this has been constructive at all.

Thank you.

Mr. SIMMONS. I thank the gentleman. If we take that in the shape of a question, Dr. Roswell?

Dr. ROSWELL. Well, I understand your frustration, Mr. Baker. And, quite frankly, I think we all share in some of that frustration. Let me point out, though, that VA has committed, is committed, and I think is making substantial progress in expanding our capacity, expanding our access to care, and providing comprehensive high-quality care. In numerous indicators, VA care is increasingly recognized as being of very high quality. I would hate to see that progress, that expanded access, that quality of care be destroyed in our enthusiasm and haste to bring everybody who needs care into a system.

My concern is that in the long run, I believe veterans are better served if we build a system of care that will address their needs, not leave it up to geographic location or a particular clinic that they might choose to use to determine what their health care benefit is on any particular day or any particular month. Ultimately, I think we have to build the system that addresses those needs. And purchasing care, because we are frustrated with waiting times, may not be the best way to do it. It might be, I don't know. I think we have to explore that in greater detail. I do believe there are a number of things that this committee could do to enhance veterans' access to care. And I appreciate the leadership of the committee in seeking those issues.

Mr. SIMMONS. Mr. Rodriguez?

Mr. RODRIGUEZ. Yes, I want to thank you for your comments. I just want to maybe get some point of clarification. As I recall, I remember getting really elated when I heard the President say he was going to allow for $3 billion the first time around. And I really got up there. And then I found out that of that $3 billion, $1.1 billion was that puffy math or efficiency management accountability. I am not sure if that was part of the ones you had referred to. And then another $1.4 was the co-payment on the part of the veterans. And then another $600 was part of the co-payment—and then I think initially, at the end came out, was about $1.3.

But all along I know the American Legion and all the other people have talked about needing about $3 billion and this $1.8 is—and each year we do put some money in. But because of the increase of numbers, and we need for infrastructure development, somehow we have got to go back and re-do our infrastructure also.

And take care some of the roofs and stuff. And so I will yield for the $1.1. Let me know if that is real money or fuzzy math.

Mr. BAKER. My point, sir, and I appreciate the gentleman yielding, my point was only that the Secretary indicated the wait list would be gone with the funds. We can talk about whether it was fuzzy or hard, whether it was real or imagined, whatever the description the gentleman chooses to make, I am simply playing back to the agency what they told us in light of where we are today. And I thank the gentleman for yielding.

Mr. SIMMONS. Mr. Murphy?

Mr. MURPHY. Thank you, Mr. Chairman. First, I want to say I did not intend to sound unduly harsh to my colleague from Florida in making comments on the bill. And have just in a brief conversation with her have come to understand that I assumed was occurring before was not, and that was that she had conversations with regard to this bill and not apparently seen this testimony until 25 hours ago. I don't find that a very acceptable position. I think that there are many issues that everybody on this subcommittee and the full committee has tremendous concerns about the long waiting lists at the VA. It has certainly been an ongoing discussion at almost every hearing we have ever had.

And I would hope that yourself and Chairman Smith would ask for more accounting from the Veterans Department for the whole committee, but certainly to the gentle lady from Florida, describing what else they recommend to do about this. What I am hearing is they have got a plan in place and it is going to work. I am not so sure it is working. And I think that she has every right to be heard, and I think her method of trying to pursue this is commendable, to try and find some way of getting something, of looking at patients first.

So I would hope that that is something that the committee might want to pursue more and get back to us on. Thank you.

Mr. SIMMONS. I thank the gentleman. And of course the reason for pursuing this issue is for just those reasons. If there are no more questions for Dr. Roswell, we will release him out of the hot seat.

Dr. ROSWELL. Thank you.

Mr. SIMMONS. And invite our final panel to appear. We are now joined by a panel of Veterans' Service Organizations. Ms. Cathleen Wiblemo, the Deputy Director for Health Care, Veterans Affairs and Rehabilitation for The American Legion; Mr. Dennis Cullinan, National Legislative Director for the VFW; Mr. Carl Blake, Associate Legislative Director for the PVA; Mr. Adrian M. Atizado, Assistant National Legislative Director for the Disabled American Veterans; Mr. Rick Weidman, Director of Governmental Relations, Vietnam Veterans of America; and Mr. Richard Jones, National Legislative Director of AMVETS. I hope you all have room at the table, and I thank you for coming before the Subcommittee. I look forward to hearing your testimony, in any order that you see fit.

STATEMENTS OF CATHLEEN WIBLEMO, DEPUTY DIRECTOR FOR HEALTH CARE, VETERANS' AFFAIRS AND REHABILITATION, THE AMERICAN LEGION; DENNIS CULLINAN, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS; CARL BLAKE, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; ADRIAN ATIZADO, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; RICK WEIDMAN, DIRECTOR OF GOVERNMENT RELATIONS, VIETNAM VETERANS OF AMERICA; AND RICHARD JONES, NATIONAL LEGISLATIVE DIRECTOR, AMVETS

STATEMENT OF CATHLEEN WIBLEMO

Ms. WIBLEMO. Mr. Chairman, members of the subcommittee, I am pleased to be here today to share the views of The American Legion regarding H.R. 2379, the Rural Veterans Access to Care Act of 2003, and H.R. 3094, the Veterans Timely Access to Health Care Act. H.R. 2379 would require the VISNs or the Veterans Integrated Services Networks to reserve 5 percent of their health care appropriations to provide services at non-VA medical facilities for veterans who must travel more than 60 minutes to a VA facility.

The American Legion believes this requirement would exacerbate an already difficult situation. Health care budgets are lamentably inadequate. Personnel and pharmacy costs take up a significant portion of a VISN's budget. To require 5 percent be reserved for rural health care reduces any further what little flexibility they have in stretching their budget to cover pressing needs throughout their geographical areas. Providing timely, quality care to veterans located in rural areas has been a challenge VA has faced for many years. The Capital Asset Realignment for Enhanced Services, or CARES initiative, in part is addressing this very concern.

An adjunct issue The American Legion would like to address is VA's capability to contract for services. Contracting for health care in designated rural and highly rural areas should be evaluated based on its enhancement of services and access to care for veterans within their community. VA oversight of the process is essential to ensure a high degree of health standard is met.

Regarding H.R. 3094, this legislation would require VA to furnish health care services in non-department facility for veterans waiting beyond 30 days for primary care. The American Legion agrees conceptually with the necessity to address this problem with VA health care. Our reservation with this legislation stems from the lack of accompanying funds to carry out this mandate.

Mr. Chairman, mandatory funding for VHA we believe is the long-term solution to these issues. Under mandatory spending, VA health care would be provided funding by law for all enrollees who meet the eligibility requirements, guaranteeing adequate appropriations for health care.

Thank you again for this opportunity, and we look forward to working with you and the subcommittee on these issues.

[The prepared statement of Ms. Wiblemo appears on p. 105.]

Mr. SIMMONS. Thank you for your testimony. The VFW.

STATEMENT OF DENNIS CULLINAN

Mr. CULLINAN. Thank you, Mr. Chairman. On behalf of the men and women of the Veterans of Foreign Wars of the United States and our ladies auxiliary, I want to express our gratitude for inviting us to participate in today's most important hearing.

The two bills under consideration today go to the heart of what we believe to be VA's gravest problem, veterans' lack of access to the VA health care system. As the President's Task Force to Improve Health Care Delivery has observed, many of those who have made the commitment to defend our country have not always received fair, equitable or appropriate access to health care once their military service has been completed. The Federal Government has been more ambitious in authorizing veteran access to health care than it has been in providing the funding necessary to match such declared intentions.

The first bill under consideration aims to improve access for veterans living in rural, isolated locations, H.R. 2379. While the VFW believes that access for rural veterans does need to be improved, and greatly so, we believe this legislation is the incorrect solution to the problem. This bill would effectively tie up a portion of the medical care appropriations solely for a distinct group of veterans. All veterans are equally eligible for VA health care. Allocating funds in this manner is not a fair or practicable solution.

We believe that like all VA health care access problems, this is an issue of funding. If VA had proper funding, it would be able to construct and fully staff more access point, such as community-based outpatient clinics to provide equitable access to all veterans throughout the country.

The other bill under consideration takes a different approach in improving access. It aims to reduce the amount of time veterans must wait for health care appointments. H.R. 3094, the Veterans Timely Access to Health Care Act, codifies VA's stated goal of seeing a veteran within 30 days of an appointment request. We support this legislation and believe this bill is a step in the right direction towards improving access to health care. It is completely unacceptable that there are still nearly 100,000 veterans who have been waiting 6 months or more for primary health care appointments and that there are still some places where they wait nearly 2 years for specialty care. It is unconscionable that our Nation treats the health care of our sick and disabled veterans so poorly.

If this bill is enacted and combined with proper funding, and I place special emphasis there, and staffing levels, those veterans who have been waiting months would be able to receive the health care they have earned through their service and defense of the nation. It would dramatically level the playing field when it comes to health care access. Veterans just as you or I can and would receive health care as they need it, not when it is convenient or possible for VA.

Additionally, we believe it would serve as an added impetus for VA to improve its own practices to incorporate workable private sector methodologies and for Congress to better fund the VA health care system. Again, special emphasis on that point. Together, improvements in these areas would render this legislation obsolete. Our veterans deserve no less.

Mr. Chairman, that completes my statement. Thank you.

[The prepared statement of Mr. Cullinan appears on p. 108.]

Mr. SIMMONS. I thank you. Mr. Blake of the Paralyzed Veterans of America.

STATEMENT OF CARL BLAKE

Mr. BLAKE. Chairman Simmons, Ranking Member Rodriguez, members of the subcommittee, PVA would like to thank you for the opportunity to testify today on H.R. 2379 and H.R. 3094.

Timely access to care is certainly something that the Department of Veterans Affairs health system is struggling with. Although PVA recognizes the difficulties that some veterans have in accessing health care, PVA believes that it is a viable system. With over 800 community-based outpatient clinics, the VA has established a good network for meeting the needs of the vastly spread veteran population.

PVA is opposed to H.R. 2379, that would allow the VA to contract health care services to local private facilities for veterans living in rural areas. PVA believes that contracting services to private facilities will set a dangerous precedent, encouraging those who would like to see the VA privatized. Privatization is ultimately a means for the Federal Government to shift its responsibility of caring for the men and women who served this country.

PVA is also troubled by the provision of this legislation that would require the VA to set aside no less than 5 percent of its annual appropriated dollars. Considering that VA health care is already severely under-funded, this requirement would only place a greater strain on a system that is struggling to meet the ever-increasing demands of our veterans.

Adequate funding must be the priority in allowing the VA to maintain its core programs, which include providing services for spinal cord injured veterans, blinded veterans, veterans who suffer from mental illnesses, and veterans who have other specialized needs. If a percentage of health care dollars is taken from the initial allocation, even the most severely disabled veterans will be at risk of less than quality care.

H.R. 3094 would establish standards of access for care within the VA health system. Access is indeed a critical concern of PVA. The number of veterans seeking health care from the VA has risen dramatically. And despite the Secretary's decision to close enrollment of Category 8 veterans earlier this year, the numbers of enrolled veterans only continues to increase as we begin adding new veterans from the war in Iraq and Afghanistan.

Unfortunately, VA health care resources do not meet the increased demand for services and the system is unable to absorb the significant increase. With tens of thousands of veterans on a waiting list, waiting at least 6 months or more for an appointment, the VA has now reached capacity at many health care facilities and closing enrollment to new patients at many hospitals and clinics.

To ensure that all service-connected disabled veterans and all other enrolled veterans are able to access the system in a timely manner, it is imperative that our Congress provide an adequate health care budget to enable VA to serve the needs of veterans nationwide. Access standards without sufficient funding are stand-

ards in name only. PVA is concerned that contracting health care services to private facilities when access standards are not met is not an appropriate enforcement mechanism for ensuring access to care.

As we stated with regard to H.R. 2379, paying for contract care out of an already inadequate VA health care appropriation draws even more resources away from the funds needed to pay for VA's core services. Likewise, contracting out to private providers will leave the VA with the difficult task of ensuring that veterans who are seeking treatment at non-VA facilities are receiving quality health care. We do think that access standards are important, but we believe that the answer to providing timely care is in providing sufficient funding in the first place. For these reasons, PVA cannot support H.R. 3094.

PVA appreciates the efforts of this committee and Congresswoman Brown-Waite to ensure that veterans receive timely access to care. However, we must emphasize that the VA will continue to struggle to provide timely access without adequate funding provided by this Congress.

We look forward to working with this committee to ensure that veterans not only receive timely access to care but high-quality care as well.

Mr. Chairman, I would like to thank you for the opportunity to testify today, and I would be happy to answer any questions you might have.

[The prepared statement of Mr. Blake appears on p. 111.]

Mr. SIMMONS. Thank you. Mr. Atizado of the Disabled American Veterans.

STATEMENT OF ADRIAN M. ATIZADO

Mr. ATIZADO. Thank you, Mr. Chairman and members of the subcommittee. I would like to thank everyone for the opportunity to present the views of DAV on the two bills under consideration on today's agenda. The first measure under consideration, H.R. 2379, its purpose is to improve access to VA health care for highly rural or geographically remote veterans. Whereas H.R. 3094 seeks to improve timely access to VA health care by using a standard of time as measured.

Insofar as H.R. 2379 considers timely access for veterans based on their geographic location and relation to a health care facility, careful consideration must be given to the mutual impact this bill has, as well as the CARES process. In addition, DAV is concerned about the setting aside of funds from VA's medical care account. Such setting aside of funds to provide highly rural veterans improved access to VA health care because it could have a negative impact on access to care by other veterans. This measure could exacerbate the wait list for veterans seeking medical care and continue the denial of enrolling for a new Priority Group 8 veterans.

With regards to H.R. 3094, we do believe clarification of the language pertaining to the amount of VA would pay for outpatient services provided by a non-Department facility is needed, as Congressman Snyder had mentioned earlier. Does VA's reimbursement refer to the full fee schedule amount or 80 percent of the fee schedule amount for which Medicare pays a physician service?

Certainly we agree no veteran should be billed for any health care service furnished by VA. However, under this measure, if a non-Department facility or provider will receive from VA the amount equal to the 80 percent Medicare pays and that facility or provider is not allowed the veteran or any entity the other 20 percent for an equitable compensation for services rendered, then we believe this Act may prove as a disincentive for non-Department facilities or providers to accept or even treat veterans.

Furthermore, we are deeply concerned that the initiative in both bills to contract care in order to meet access standards would shift medical services and veteran patients from VA to the private sector. Now this proposal to contract care to non-Department facilities and providers, we believe it would encourage VA to refer patients and dollars used to subsidize their care outside a system specifically created for veterans and their health care needs. This proposal, we believe, sets a dangerous precedent, that if allowed to expand could erode VHA's patient resource base, undermining VHA's ability to maintain its specialized service programs and endanger the well-being of veteran patients. We are talking about the high-quality care VA is well known for worldwide.

In the years since open enrollment, VA has been forced to do more with less even though over the past two budget cycles, Congress has increased discretionary appropriations for veterans health care. The funding levels have simply not kept pace with inflation and significant increase in demand for services. DAV agrees that veterans must have timely access to health care and that VA must be held accountable for meeting its own access standards. However, to provide timely access to care, we must identify and immediately correct the underlying problems, not the symptoms, which these two bills I believe are trying to solve.

We do oppose other initiatives that—I am sorry, we do not oppose other initiative assisting veterans who reside in under-served areas. We are however opposed to any initiative that would turn VA into an insurer rather than a provider of health care. If given proper funding, VA should be held accountable for meeting demand in a timely manner. And only as a last resort would we want care to be contracted out. Moreover, if VA receives sufficient appropriation, it should be able to plan for the appropriate number of staff necessary to provide veterans within VA facilities in a cost-effective manner.

Mr. Chairman, that concludes my remarks. I appreciate the subcommittee allowing us the opportunity to provide testimony. I would be happy to answer any questions.

[The prepared statement of Mr. Atizado appears on p. 114.]

Mr. SIMMONS. Thank you. Mr. Weidman.

STATEMENT OF RICK WEIDMAN

Mr. WEIDMAN. Mr. Chairman, I wish to thank you for the opportunity for Vietnam Veterans of America to comment on these two well-intentioned and heartfelt bills, the Veterans Timely Access to Health Care Act. Ms. Brown-Waite, we want to thank you for introducing that. As well as the Rural Veterans Access to Care Act of 2003.

The thing that I think that has been pointed out and is the heart that has already been said is the only immutable law up here on the Hill, which is the law of unintended consequences that will result from either of these acts. We are deeply worried about that and believe that the crux of the issue comes right back to, if we may suggest, back to the lack of funding. We are not short $1.8 billion for next year. If you use the Medicare formula beginning on a per capita basis since 1996, the President should have asked for $35.9 billion just for medical operations for fiscal year 2004.

The problem was the base years back under a previous President and a previous Speaker. It happened on a previous watch but the consequences are on this watch. And therefore it is incumbent, we believe, upon this President and this Congress, both sides of the aisle, to unite and figure out a plan to restore the VA health care budget to where it should have been, number one. Number two, the VA construction budget to where it should have been and not be trying to take it out of veterans' health care funds.

That in and of itself is not the panacea. Ms. Brown, we do not object to——

Ms. BROWN-WAITE. Ms. Brown-Waite.

Mr. WEIDMAN. I beg your pardon, ma'am.

Ms. BROWN-WAITE. I am going to be here for a while. I suggest you learn my name.

Mr. WEIDMAN. I do beg your pardon, ma'am. I meant no disrespect. VVA has never objected to contracting out when it is in the interest of the individual veteran. And, in fact, when the proposal came up 3 years ago in North Central Florida, we did stand for it, that particular proposal.

But we have difficulties in standing for this at this particular time, although we are not necessarily against the concept simply because every VA hospital has been allowed to have its own accounting system. We have brought that to the attention of this committee, of this subcommittee, of the full committee, and of the appropriations committee time and time again about the need to standardize accounting systems. And therefore I don't know that we would ever be able to track back what exactly happened to the money that was contracted out.

A similar problem plagues the proposal advanced by Mr. Osborne of how would you ever track that 5 percent and hold people accountable for it. May I suggest that in terms of contracting out, which is not dissimilar conceptually on a temporary basis from that which has been proposed and as implemented by the Secretary in regard to pharmaceuticals, that the same thing on a temporary basis might make sense in this case on access to care.

But people are not being held accountable in senior management. The VA health care system and the VA overall gave managers last year bonuses in excess of an average of $11,700. It was something like that. It was well over $11,000. And this is something, for what? For long waiting lines? For not managing, getting the bang for the buck from the health care dollars that we have?

And so it would strike me, ma'am, to start to and, Mr. Chairman, to contract out at this particular time without taking some steps through the Congress to demand accountability out of senior management, to demand an accountability system on the money, to be

able to track the money right down to each hospital level, down to each clinic. And without demanding a modern management information system when it comes to personnel, so that you know how many clinicians of what sort you are getting for the dollar in each and every facility in this country are the steps that we should be taking first.

The problem with some of the goals and mandating goals, an example is right here. It was pointed out earlier about the 1996 law but this is a strategic goal plan prepared by VA on a periodic basis. What we have here is the one for 2003 to 2008. All of the organizations represented at this table made significant input and right up to the original draft back to them, they did change quite a bit this year. But the problem is it is not measurable, number one. And, number two, this committee has never held—I beg your pardon, one hearing in my recollection that holds VA accountable for what they say in their strategic plan and/or what did they say in their GPRA plan, the Government Performance and Rating Act for the monies that they are asking, and actually hold the VA accountable both before this committee and before the appropriations committee.

That are the only comments the VVA has at this time. We are looking forward to working with members on both sides of the aisle towards really truly proper full funding.

And, again, Ms. Brown-Waite, I want to apologize, ma'am.

[The prepared statement of Mr. Weidman appears on p. 117.]

Mr. SIMMONS. I thank the gentleman for his testimony. Am I correct in understanding that he requests the white paper to be inserted into the record?

Mr. WEIDMAN. With the Chair's and the committee's permission, sir.

Mr. SIMMONS. Without objection, so ordered.

(See p. 120.)

Mr. SIMMONS. Mr. Jones of the AMVETS.

STATEMENT OF RICHARD JONES

Mr. JONES. Chairman Simmons, Ranking Member Rodriguez, Representative Brown-Waite, on behalf of AMVETS' national commander, John Sisler, and the nationwide membership of AMVETS, I am pleased to offer our views to your subcommittee on the matters before the panel. Both of the bills currently before the panel address concerns voiced by AMVETS and other veteran service organizations over many of the past years. Clearly, providing the best possible health care to our Nation's veterans is a difficult task given the current circumstances of chronic under-funding.

VA already struggles with an inadequate budget and too many veterans are barred from access for reasons unrelated to the distance they reside from medical facilities. It will not be easy to resolve this access to care issue. As we watch this year's appropriations process, our concerns rise. Knowing that too many sick and disabled veterans may have to continue their wait. Or, depending on who they are, be denied enrollment altogether.

It is important, nonetheless, that we do our honest best to meet our promise to provide quality care in return for military service in the defense of this country.

H.R. 2379, the Rural Veterans Access to Care Act of 2003, would allow the VA to contract for care with local medical providers in instances where the veteran would otherwise have to travel at least 60 minutes or greater for VA care. While it may be impossible to expect that every veteran living in a rural area could find every VA health care service close to home, clearly, sick and disabled veterans should not be overlooked simply because they live in a sparsely populated area. However, AMVETS is concerned with the provision that earmarks 5 percent of VA medical care funds to local contracts outside the VA system. AMVETS believes that the more practical way may be to open more community-based outpatient clinics. This type of approach would help meet our commitment to veterans in rural areas. One caveat, however, is to ensure that should we open these clinics, we must be guarded to make sure that we don't displace funding intended for VA's obligation for quality specialized programs, such as blind rehabilitation, spinal cord injury, and other such programs to veterans who truly need it.

Regarding H.R. 3094, the Veterans Timely Access to Health Care Act, AMVETS firmly supports the goal of requiring timely attention to the health care needs of veterans. Establishing a 30-day standard of access for veterans seeking health care from VA would attain a measurement of success that we have recommended numerous times over the past years to this panel and other congressional forums, including the appropriations subcommittee. Despite VA's establishment of such a goal in 1995, we are all aware that meeting the 30-day standard is a continuing challenge. Meeting this level of success requires, AMVETS believes, more than good intentions or the setting of a national goal to get the job done. As the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans noted, "To ensure maximization of resources, the most cost-effective and timely delivery of quality care must be implemented."

And of course the task force also concluded that the current mismatch in VA between demand and available funding impedes veterans' access to timely care. So there is already a challenge, a mismatch, if you will, between VA health care delivery and demand. AMVETS strongly supports the 30-day standard. We would love to see it work whether in rural, urban, or wherever in America for veterans.

However, the improvement of health care delivery is dependent on a number of elements that may be beyond the reach of standard settings. Key among these we believe is funding. The veterans and members of AMVETS have watched as overworked medical staffs attempted to carry on. But the bottom line is that vital services have been reduced or eliminated. Medical care has been rationed. And in the process, the veterans population has been woefully under-served. We believe the VHA is currently well led. We also believe that efficiencies can be found to strengthen VA's management of clinical functions. However, our best analysis of this matter identifies inadequate funding as the central issue challenging the VA health care system.

Mr. Chairman, in closing, AMVETS looks forward to working with you and others in Congress to find the very best ways to ex-

tend health care to veterans in rural areas, and to ensure the earned benefits of all of America's veterans are strengthened and improved. AMVETS thanks the panel for the opportunity to address this matter.

[The prepared statement of Mr. Jones appears on p. 137.]

Mr. SIMMONS. I thank all the panelists for their comments. I will refer to the final report of the President's Task Force, Recommendation 5.2, and the text preceding it, "Providing sufficient funding to VA will not by itself guarantee timely access to primary or speciality care appointments." And the recommendation, as I think most of you know, states that, "VA facilities should be held accountable to meet the VA's access standards for enrolled groups Priority 1 through 7." The VA standard is essentially what I understand Ms. Brown-Waite wants to place in statute. I guess it seems to me that placing such a standard in statute would have some positive effect on meeting those requirements because if you don't, you are essentially breaking the law.

And while we all realize that there is a funding issue, I suppose there is always going to be a funding issue, but Members of this Subcommittee certainly and I would say virtually all the members of the Committee fought hard for funding on the House side and we continue to fight hard for that funding in conference.

Dr. Roswell has indicated that that exact degree of funding doesn't really make much difference from his perspective. And so I guess I come back to the issue of requiring by statute that certain standards be met. Do you as a group agree or disagree, would you like to comment on that?

Mr. WEIDMAN. Did you mean standards in general, Mr. Chairman?

Mr. SIMMONS. No, specifically standards with regard to timely access to care.

Mr. WEIDMAN. The standards in regards to timeliness to access from VVA's point of view has to be tied to repercussions against local management at every level of the chain of events.

Mr. SIMMONS. In other words, no more bonuses.

Mr. WEIDMAN. Well, that would be only one.

Mr. SIMMONS. We are going to raise our hand and say no more bonuses for people that don't meet these standards?

Mr. WEIDMAN. Well, that would be only one, sir. And I am afraid that the tracking of more contracts, they can't even track the dollars you give them now at the local hospital level. To make them standardize their accounting system at 163 or 158, or whatever it is this week, medical centers is important to be able to know where the dollars are going because it directly affects the individuals in key positions.

And I would say more than that. If they are contracting out, no step increases, among managers I am talking about now. No staff increases, no bonuses, no awards, no anything until such time as they start to meet the agreements. People say, "You can't do that, that is federal employment." Well, by gosh, everyone in our military and every one of us in this room served in the military and we were federal employees, and we had standards and we kept them.

Mr. SIMMONS. And there weren't bonuses as I recall.

Mr. WEIDMAN. I don't recall those either.

Mr. SIMMONS. You did your duty. Didn't you just do your duty?

Mr. CULLINAN. Mr. Chairman, on behalf of the VFW, I would just add one other thing. One benefit to mandating access standards, in a sense that mandates the provision of adequate funding. So you could have a positive cycle as opposed to a vicious one. So I think that is one way of looking at it.

Mr. SIMMONS. Now we are cooking. Mr. Rodriguez?

Mr. RODRIGUEZ. Let me thank all of you for being here and for what you do. I think you really provide a service to our veterans out there. And one of the realities is that just for cost of living, what is it, it is 7 to about 11 percent in health care? That in itself, somebody correct me on that, I think it was 7 at the minimum and up to 11, and just for the cost of living, the cost of health care, that percentage, we haven't even kept up with that. And so not to mention the number of veterans that have been coming in. And when people argue about put in more money, we are putting in more money, the bottom line is we haven't even been paying for the cost of living. And so I think it is important for us to recognize that.

I was interested to see in terms, and I will just get your feedback because I know that there is another piece of legislation out there, the mandatory funding that we are trying to push, I wanted to get your feedback on that, just from each one of you, how that might help to improve both the quality of care and services?

Mr. BLAKE. Mr. Rodriguez, I would like to speak to that, if I may. Mandatory funding would solve a lot of problems. You look at the current fiscal year, we got a pretty decent appropriation for health care compared to past years. Unfortunately, it arrived 6 months late. So right there is a problem. Mandatory funding would not only ensure enough money to do the job right but it would get there in a timely manner. And would allow VA managers to plan. Right now, they are not sure how much they are going to get or when they are going to get it. And it really puts them in a difficult position. Mandatory funding would be tremendous.

Mr. RODRIGUEZ. The other members?

Ms. WIBLEMO. For the American Legion, again, and it is reflected in our testimony pretty much what my colleague said next to me, mandatory funding would allow the VA to plan ahead and not start a fiscal year in the red all the time. So we believe it would really, really help as far as health care, obviously as far as health care is concerned.

Mr. JONES. AMVETS fully supports mandatory care. There is no doubt that once you match up the number of veterans that are projected to seek access to a health care system and then determine the costs of that care, calculating in a traditional index for the growth of medical inflation, you have the formula for a system that may well work and for a system where VA could well carry out its duties.

May I just comment for a second on the decision whether or not we should go for a 30-day standard implemented by legislation. We at AMVETS are very concerned with recent decisions that bar the enrollment of certain veterans to the system. And we gauge that as a reaction to the lack of resources. We are very fearful that if you should go forward enacting a 30-day standard, as much as we

would like it, the Secretary still has what was referred to earlier today by Mr. Roswell, an ability to exercise an enrollment decision. If they are forced to meet a 30-day standard, what enrollment decision would be made in the future. Would VA exclude Priority 7s, Priority 6s? Congress and the administration have got to get together here and respond, despite all your hard work, and we applaud that, to the funding needs in the VA health care system.

Mr. BLAKE. Mr. Chairman, I would just like to emphasize that the independent budget this year made mandatory funding perhaps its most priority issue. The one thing that mandatory funding would do, as mentioned by my colleagues, it would guarantee that the VA would have the money it needs to meet the needs of all of the veterans within VA and the VA would know that in advance and be able to plan for that. Unlike the situation we are in now where we have this ongoing shell game of an appropriations process where we know they are not actually getting the funding level they need to meet the demands of all veterans.

To go back to the previous question real quick about the 30-day access standards and needing to hold the VA accountable, I don't think anyone here would disagree that the VA needs to be held accountable. But to mandate access standards without the funding, we are basically setting the VA up for failure because we already know, or we would agree, that the VA perhaps cannot meet that access standard with the funding level it has now. So why mandate an access standard without providing the funding and giving the VA at least a level chance to try to meet that access standard. And that is the situation we would be putting the VA in, which would almost certainly guarantee that they would be forced to contract out services and that just goes into a far broader spectrum that would set the VA up for future failure.

Mr. RODRIGUEZ. I have got two more responses before it turns red.

Mr. ATIZADO. Real quick, thank you, Congressman. Along with PVA and obviously the other veteran service organizations on this panel, I do echo what they are saying about mandatory funding. But I would also like to point out about PTFs final report. In that same chapter from which you draw the idea of accountability for meeting established standards, I would urge you to read in the conclusion section prior to that recommendation the sentence which precedes it that says, "Congress and the Executive Branch must work together to provide VA with full funding to meet demand within the access standard." So I would just caution a mandatory or at least a codified standard without adequate funding.

Mr. RODRIGUEZ. I don't have any more time, but do you want to react to the mandatory funding?

Mr. WEIDMAN. VVA is strongly in favor of mandatory funding but not the current bill because the problem with the current bill is it starts us out at too low a level. If you will look on page 6 of the appendix to our testimony, you will note that per capita cost of a VA patient fell by 58 percent since 1996. Excuse me, it fell by 30 percent while the national average, which includes Medicare, rose by 54 percent. That is an 80 percent difference. If you are going to move towards mandatory care, then we have got to peg it high enough on a per capita basis to begin with, number one. And,

number two, base it on the Center for Medicare and Medicaid Services at least and not on the consumer price index because it is always a much higher figure.

Mr. RODRIGUEZ. Thanks very much.

Mr. SIMMONS. Ms. Brown-Waite?

Ms. BROWN-WAITE. Thank you very much. First of all, I want to thank all of the panelists for being here. As I said before, I am new here. One of the things that a veteran service officer, and it is not Mr. Kenney who was here but another veteran service officer back in the district, said to me was, "When you go there and you go to fight for veterans, you know who is going to be opposing it? The people who accept inadequate health care right now. They accept it and they will hide behind the issue of funding." I want to get as much funding as possible for veterans health care. And I am not alone on this panel. I think it is a bipartisan effort. But I think that Mr. Cullinan hit the nail on the head when he said, "Maybe if we hold their feet to the fire, the appropriations will follow." Sometimes you have to take that bold step and say, "We are mad as hell, and we are not going to take it anymore. We are not going to have veterans waiting in line." Then the money will come.

I also heard, remember, too, that no bill that leaves here has an appropriation attached to it. That is a separate process. I heard about the dangerous precedent that this bill would set. Well, let me share with you that Mr. Kenney brought me a list that was compiled September 26th of 30 people who have been waiting for health care. And four of them got lost in the system. Now what that means is they asked for an appointment, VA lost their name, never had any record of it. They "got lost in the system."

But let me share with you something that you should be concerned about. I never met Salvatore Boriello, I never met the man. I have never had the opportunity to because he applied November 16, 2001, and the man died May 14, 2003. I may meet his widow. He was waiting 18 months at the time of death.

That, to me, is a dangerous precedent. It is not a precedent, it is a practice. And as long as we don't continue to work together to end that practice, then there will be much longer lists than this out of 30 who die waiting for service. I don't know whether Mr. Boriello was a member of The American Legion, the PVA, DAV, the VVA, or AMVETS, I don't know the answer to that. But what do I tell Mrs. Boriello when I go home, when I do meet her? And I say, "You know I tried to make sure that there wasn't another Mr. Boriello and all I heard was, 'It can't work.'" What do I tell her? And I am sure every member of this panel have similar cases in their district. What do we say? We tried to fix it?

If you build it, they will come. And if you mandate it, the funding will come. I don't buy the we are going to inadequate health care if we pass this bill or if we pass the other bill. I think we need to strive higher. I think we need to set higher standards and there is no better way to do it than with a mandate. There is absolutely no better way to do it.

Mr. SIMMONS. I thank the lady for her statement and for her legislation which has resulted in this hearing this afternoon. If there are no more questions or comments for the panel, I thank the panel

for their testimony and for their patience in sitting through this afternoon.

I have a statement from Representative Cliff Stearns, which is his statement for the record. And I ask unanimous consent that it be included. I thank the gentleman.

[The statement of Congressman Stearns appears on p. 77.]

Mr. RODRIGUEZ. And I just personally want to thank the American Legion for inviting me to St. Louis. I had a great time down there. And that is during the same time the VFW was in my backyard that didn't invite me but thank you.

Mr. SIMMONS. Okay.

Mr. CULLINAN. I will look into that, sir.

Mr. SIMMONS. I ask that the remainder of my statement be introduced into the record as if read.

I believe we have engaged in an informative debate today on one of the most important topics before this Committee, how to ensure veterans who served our Nation can gain reasonable access to a crowded and over-stressed VA health care system. We have two bills with different approaches to answering that question, and we heard much about underlying causes for the long waits being experienced by veterans. It certainly relates to funding, but as the PTF said in its report, the whole story of access to care in VA is not funding alone. As Mr. Kenney testified, the prospect of a forced contracting out might make VA more efficient in delivering health care to veterans who have waited much too long for it.

I want to thank our witnesses and our Subcommittee members for their assistance and attention to these matters. I appreciate Mr. Osborne's attendance and active participation, as well, particularly for the quality of the discussion we have conducted today on a very important topic, improving access to VA health care for all veterans.

I thank you all again for your participation.

This hearing is adjourned.

[Whereupon, at 5:40 p.m., the subcommittee was adjourned.]

APPENDIX

I

108TH CONGRESS
1ST SESSION

H. R. 2379

To amend title 38, United States Code, to improve access to health care for rural veterans, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JUNE 5, 2003

Mr. OSBORNE introduced the following bill; which was referred to the Committee on Veterans' Affairs

A BILL

To amend title 38, United States Code, to improve access to health care for rural veterans, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Rural Veterans Access to Care Act of 2003".

SEC. 2. IMPROVED ACCESS TO HEALTH CARE FOR RURAL VETERANS.

(a) IN GENERAL.—(1) Chapter 17 of title 38, United States Code, is amended by adding at the end the following new section:

"§ 1730A. Access to care for rural veterans

"(a) The Secretary shall ensure that funds allocated pursuant to subsection (b) are used in accordance with that subsection to improve access to medical services for highly rural or geographically remote veterans by using the contract authority of section 1703 of this title and other authorities available to the Secretary to improve such access to care.

"(b)(1) The Secretary shall provide that, of the amounts made available for any fiscal year for the Medical Care appropriation for the Department, not less than 5 percent shall be available only for treatment of veterans described in subsection (c) for—

"(A) acute or chronic symptom management;

"(B) nontherapeutic medical services; and

"(C) other medical services as determined appropriate in the case of any veteran by the director of the appropriate geographic service region of the Department, after consultation with the Department physician responsible for primary care of the veteran.

"(2) In the allocation of such percentage of funds to geographic service regions of the Department, such funds for any fiscal year shall initially be allocated in an identical percentage to each such service region. However, upon a determination by the Secretary that a particular

service region will not use all of the funds so allocated for a fiscal year for highly rural or geographically remote veterans, the Secretary shall reallocate those funds to one or more other service regions, to be available only for treatment of veterans described in subsection (c) for purposes described in paragraph (1).

"(c) Veterans referred to in subsection (b)(1) as described in this subsection are veterans—

"(1) who are enrolled in the veterans health care system under section 1705 of this title or have a service-connected disability; and

"(2) who, pursuant to subsection (e), are considered to be highly rural or geographically remote veterans.

"(d) After the end of the third fiscal year during which this section is in effect, the Secretary shall review the operation of this section and, if the Secretary determines that an adjustment in the percentage in effect under subsection (b)(1) is necessary, shall recommend to Congress an adjustment to such percentage. The Secretary shall include with any such recommendation a recommendation as to whether the Secretary should have the authority to apply the overall percentage through the use of different percentages for the various geographic service regions of the Department.

"(e) The Secretary shall prescribe by regulation the veterans considered to be highly rural or geographically remote veterans for the purposes of this section. The Secretary shall include as such a veteran any veteran for whom the driving time to reach a Department health-care facility is 60 minutes or greater. The Secretary may provide for a lesser driving time in the case of any veteran if the Secretary determines that a driving time of 60 minutes or greater imposes a hardship on such veteran or otherwise is in the best interest of the veteran.".

(2) The table of sections at the beginning of such chapter is amended by adding at the end the following new item:

"1730A. Access to care for rural veterans.".

(b) EFFECTIVE DATE.—Section 1730A of title 38, United States Code, as added by subsection (a), shall take effect beginning with funds appropriated for fiscal year 2005.

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108TH CONGRESS
1ST SESSION

H. R. 3094

To amend title 38, United States Code, to establish standards of access to care for veterans seeking health care from the Department of Veterans Affairs, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 16, 2003

Ms. GINNY BROWN-WAITE of Florida (for herself, Mr. PEARCE, Mr. GREEN of Wisconsin, Mr. PAUL, Mr. BRADLEY of New Hampshire, Mr. FROST, Mrs. BLACKBURN, Mrs. JO ANN DAVIS of Virginia, Mr. SCHROCK, Mr. RENZI, Mr. COLE, Mr. MICA, Mr. FOLEY, Mr. MARIO DIAZ-BALART of Florida, Mr. GUTKNECHT, and Mr. JONES of North Carolina) introduced the following bill; which was referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38, United States Code, to establish standards of access to care for veterans seeking health care from the Department of Veterans Affairs, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Veterans Timely Access to Health Care Act".

SEC. 2. STANDARDS FOR ACCESS TO CARE.

(a) REQUIRED STANDARDS FOR ACCESS TO CARE.—Section 1703 of title 38, United States Code, is amended by adding at the end the following new subsection:

"(d)(1) For a veteran seeking primary care from the Department, the standard for access to care, determined from the date on which the veteran contacts the Department seeking an appointment until the date on which a visit with a primary-care provider is completed, is 30 days.

"(2)(A) The Secretary shall prescribe an appropriate standard for access to care applicable to waiting times at Department health-care facilities, determined from the time at which a veteran's visit is scheduled until the time at which the veteran is seen by the provider with whom the visit is scheduled.

"(B) The Secretary shall periodically review the performance of Department health-care facilities compared to the standard prescribed under subparagraph (B). The Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives an annual report providing an assessment of the Department's performance in meeting that standard.

"(3) Effective on the first day of the first fiscal year beginning after the date of the enactment of this section, but subject to paragraph (4), in a case in which the Secretary is unable to meet the standard for access to care

applicable under paragraph (1) or (2), the Secretary shall, or with respect to a veteran described in section 1705(a)(8) of this title may, use the authority of subsection (a) to furnish health care and services for that veteran in a non-Department facility. In any such case—

"(A) payments by the Secretary may not exceed the reimbursement rate for similar outpatient services paid by the Secretary of Health and Human Services under part B of the medicare program (as defined in section 1781(d)(4)(A) of this title); and

"(B) the non-Department facility may not bill the veteran for any difference between the facility's billed charges and the amount paid by the Secretary under subparagraph (A).

"(4) Paragraph (3) shall not apply to a veteran enrolled or seeking care at a Department facility within a Department geographic service area that has a compliance rate, determined over the first quarter of the first calendar-year beginning after the date of the enactment of this Act, for the standards for access to care under paragraphs (1) and (2) of 90 percent or more. The Secretary shall make the determination of the compliance rate for each Department geographic service area for purposes of the preceding sentence not later than July 1 of the first

calendar-year beginning after the date of the enactment of this Act.

"(5)(A) The Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives for each calendar-year quarter, not later than 60 days after the end of the quarter, a comprehensive report on the experience of the Department during the quarter covered by the report with respect to waiting times for veterans seeking appointments with a Department health-care provider.

"(B) Each report under subparagraph (A) shall include the total number of veterans waiting, shown for each geographic service area by the following categories:

"(i) Those waiting under 30 days for scheduled appointments.

"(ii) Those waiting over 30 days but less than 60 days.

"(iii) Those waiting over 60 days but less than 4 months.

"(iv) Those waiting over 4 months but cannot be scheduled within 6 months.

"(v) Those who are waiting over 6 months but cannot be scheduled within 9 months of seeking care.

"(vi) Those who cannot be scheduled within one year of seeking care.

"(vii) Any remaining veterans who cannot be scheduled, with the reasons therefor.

"(C) For each category set forth in subparagraph (B), the report shall distinguish between—

"(i) waiting times for primary care and specialty care; and

"(ii) waiting times for veterans who are newly enrolled versus those who were enrolled before October 1, 2001.

"(D) Each such report shall also set forth the number of veterans who have enrolled in the Department's health care system but have not since such enrollment sought care at a Department health care facility.

"(E) The final report under this paragraph shall be for the quarter ending on December 31, 2010.".

(b) EFFECTIVE DATE.—Subsection (d) of section 1703 of title 38, United States Code, as added by subsection (a), shall take effect on the first day of the first month beginning more than six months after the date of the enactment of this Act. The first report under paragraph (5) of that subsection shall be submitted for the

quarter ending on December 31 of the first calendar year beginning after the date of the enactment of this Act.

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PREPARED STATEMENT OF CHAIRMAN SIMMONS

The Subcommittee will come to order.

Welcome fellow Members, distinguished witnesses and others in attendance.

This is a legislative hearing to consider two bills referred to the Subcommittee. The first bill, H.R. 2379, was introduced by the distinguished gentleman from Nebraska, Mr. Tom Osborne, on June 5, 2003. The Rural Veterans Access to Care Act of 2003 would attempt to improve access to VA health care for veterans who live in rural and remote areas. The second bill was introduced on September 16, 2003, by my fellow Committee Member—the gentlewoman from Florida, Ms. Ginny Brown-Waite and others. H.R. 3094, the Veterans Timely Access to Health Care Act, would establish standards of access to care for veterans seeking primary care from the Department of Veterans Affairs.

As a Life Member of the American Legion and a Vietnam Veteran, I believe that veterans should not have to wait—or wonder—whether they will get any medical services from the VA. Access to timely VA health care is a vexing issue that this Subcommittee has examined, discussed and struggled with in this session and the past Congress.

The General Accounting Office (GAO) has issued two reports on the subject of access and waiting times, highlighting VA's slow and too often spotty improvements from 1999 to 2001.

Also, the report of the President's Task Force (PTF) to Improve Health Care Delivery for our Nation's Veterans was issued this year and echoed the same concerns about waiting times and VA's inability to meet its own published access standards. Recommendation 5.2 of the PTF report suggested that VA facilities be held accountable for meeting VA's access standards. The PTF said that VA should be required to arrange for care with a non-VA provider when VA couldn't offer a reasonable appointment, unless the veteran elected to wait for an available appointment in VA.

Delayed health care is denied care. The task before us today is to examine two potential legislative solutions for veterans living in rural or geographically remote areas and for veterans seeking primary care appointments who are unable to be seen within 30 days of need.

Mr. Osborne's bill would set aside at least 5 percent of the available appropriation each year to invest in access to care for rural veterans. This bill would also require the Secretary to issue certain regulations and conduct periodic reviews of the operational provisions of this bill and the allocation of funds.

I'm very pleased that Ginny Brown-Waite is with us today to discuss her bill, H.R. 3094, which would establish access standards in law for veterans seeking VA primary health care. Long before the PTF was formed, the former Under Secretary for Health, Dr. Thomas Garthwaite, testified before this Subcommittee at a hearing on April 3, 2001, that—and I quote:

> VHA is committed to providing timely care to the veterans enrolled in our health care system. We have recently developed a data system and performance expectations with regard to waiting times for primary care and specialist consultation. We believe that our performance goals for waiting times, commonly known as '30—30–20,' are industry leading and fully support patient expectations for timely access to care. Our strategic goal is to provide 90 percent of new primary care and specialty care visits within 30 days, and see 90 percent of patients within 20 minutes of theirscheduled appointment time.

Ms. Brown-Waite's bill would codify part of what VA has claimed in public to be its policy for more than three years.

Does my friend Mr. Rodriguez of Texas, our Ranking Member, have an opening statement he wishes to make?

Thank you Mr. Rodriguez.

Welcome our first panel. We have two colleagues and Members of Congress here to testify, beginning with Tom Osborne of Nebraska, who introduced the Rural Veterans Access to Care Act of 2003. I'd like to note for the record that Mr. Osborne served his country for six years in the Army National Guard and Army Reserves. Thank you for your service Tom.

Our colleagues Jon Porter of Nevada has also joined us to provide their testimony on the legislation we are considering. We will begin with Mr. Osborne, and then Mr. Porter. Please proceed.

Thank you for your testimony.

I'd like to thank Tom Osborne and Jon Porter for sharing time with the Subcommittee. We will consider your advice on these matters very carefully. Let it be shown for the record that our colleague, Charlie Stenholm of Texas, has provided

a written statement. We would like to acknowledge him for his thoughtful input, as well.

For our second panel, we welcome two veterans who have made the journey to Washington, DC, to testify before this Subcommittee: Mr. Arthur L. Johnsen, a Veterans Service Officer from Franklin County, Nebraska; and Mr. John J. Kenney, a Veterans Service Officer from Citrus County, Florida.

Thank you for your testimony.

Testifying on our third panel, representing the Department of Veterans Affairs, is Dr. Robert Roswell, Under Secretary for Health. We appreciate your appearing today, Mr. Secretary.

I'd like to thank Under Secretary Roswell for appearing before us today. We appreciate the value of your testimony, even when we disagree with you.

Our fourth panel, representing national veterans service organizations: Ms. Cathleen Wiblemo, Deputy Director for Health Care, Veterans Affairs and Rehabilitation for The American Legion; Mr. Dennis Cullinan, National Legislative Director for the Veterans of Foreign Wars; Mr. William Carl Blake, Associate Legislative Director of Paralyzed Veterans of America; Mr. Adrian M. Atizado, Assistant National Legislative Director for the Disabled American Veterans; Mr. Rick Weidman, Director of Government Relations, Vietnam Veterans of America; and Mr. Richard Jones, National Legislative Director of AMVETS.

Thank you for your testimony.

This has been a very interesting and helpful hearing.

I believe we have engaged in an informative debate today on one of the most important topics before this Committee—how to ensure veterans who served our nation can gain reasonable access to a crowded and overstressed VA health care system. We have two bills with different approaches to answering that question, and we heard much about underlying causes for the long waits being experienced by veterans. It certainly relates to funding, but as the PTF said in its report, the whole story of access to care in VA is not funding alone. As Mr. Kenney testified, the prospect of a forced contracting out might make VA more efficient in delivering health care to veterans who have waited much too long for it.

I want to thank our witnesses, and our Subcommittee Members, for their assistance and attention to these matters. I appreciate Mr. Osborne's attendance and active participation as well, particularly for the quality of the discussion we have conducted today on a very important topic—improving access to VA health care for all veterans.

We thank you all for attending.

We are adjourned.

STATEMENT
CIRO RODRIGUEZ
RANKING DEMOCRATIC MEMBER
SUBCOMMITTEE ON HEALTH
LEGISLATIVE HEARING ON H.R. 2379 AND H.R. 3094

Good afternoon, Mr. Chairman. I appreciate your holding this important hearing today. I welcome the opportunity to discuss the very real access challenges VA is confronting. As with many things, Mr. Chairman there seems to be great consensus on the problems VA is facing, but not as much agreement on the solutions.

Many of us believe that the ability of the VA medical system is directly related to its funding. As long as VA continues to have inadequate budgets and unprecedented demand for services, it will continue to have access problems. That's why I support mandatory funding for VA health care. I hope we will be able to discuss that on a later date.

I hope that you will also agree, Mr. Chairman, to hold a hearing on the far-reaching Capital Asset Realignment for Enhanced Services (CARES) plan VA has proposed to transform its infrastructure to respond to veterans' health care needs. I know you likely share my view that this process could have a significant effect on veterans' access to health care.

I thank you, Mr. Chairman for giving us an opportunity today to discuss the bill on access standards offered by Congresswoman Brown-Waite. Many of us expressed some concerns about the implications of the bill and this hearing gives us an opportunity to have those concerns addressed.

One concern is the diversion of resources shifting care from almost every network into primary care settings in the private sector might cause. Even though VA is documenting improvements, there are still many veterans waiting longer than 30 days for primary care appointments. Dr. Roswell will testify that none of the networks would meet the 90% compliance rate for the average percentage of enrolled veterans who are able to schedule primary care appointments within 30 days. Every network would have to provide contract primary care to some veterans.

It is unclear what effect this would have on VA's ability to deliver its in-house services, but the resources to pay for private-sector care for more

veterans clearly must come from somewhere, and unfortunately it does not appear they will come from this Congress. If VA had adequate resources, enforcing VA's stretch goal for waiting times would be fine, but I believe everyone on this Committee knows better. We also know that VA has become an increasingly efficient provider. The easy cuts have already been made. I believe this bill would force VA to either cut more veterans off or further limit the services it provides to veterans. I do not believe for an instant that the bill's advocates intend these outcomes, but I do believe that this would be the result of enforcing a goal only one network seems capable of meeting on an already overburdened health care system. In my view, we cannot continue to ask VA to do more and more with less and less.

We will also be considering H.R. 2379 introduced by the gentleman from Nebraska, Mr. Osborne. According to the analysis VA recently did for CARES, parts of my district have the worst access to hospital care in the country. Veterans in McAllen, Texas must travel up to 6 hours one-way to reach the San Antonio VA Medical Center so I am well acquainted with the access problems Congressman Osborne is trying to address. I am not as sure that we completely understand the implications of his ambitious bill. VA says that only about 1.6% of its enrollees would be considered geographically remote veterans, yet this bill would require VA to spend 5% of its budget addressing their needs. As we attempt to standardize access throughout the nation, I am not sure this would represent an improvement in addressing this problem.

That said, I do want to thank the Members who have brought these bills before us. I appreciate their contribution to this important dialogue and I look forward to the testimony of our witnesses.

STATEMENT FOR THE RECORD

Committee on Veterans' Affairs
Health Subcommittee Hearing on
The Veterans Timely Access to Health Care Act
09/30/2003

Honorable Ginny Brown-Waite

Thank you, Mr. Chairman, for the opportunity to discuss the importance of H.R. 3094, The Veterans' Timely Access to Health Care Act which I introduced with Mr. Bradley of New Hampshire and Mr. Renzi of Arizona on September 16, 2003.

Nationally, over **59,000** veterans who have enrolled in the VA's health care system cannot be seen at their preferred site within **six months**, and are placed on a waiting list. In Florida there is a backlog of more than **12,000** veterans seeking VA medical care. I hear daily from my constituents that are not able to receive the care promised to them.

Amazingly, this number is down dramatically from the number of veterans waiting longer than six months just one year ago. The success is no doubt a testament to the hard work and dedication of Secretary Principi and Undersecretary Roswell. I applaud their efforts.

However, the current situation is still unacceptable. As members of the US Congress serving on the Veterans Affairs Committee, we all have a duty to those who have fought and served our nation. We must fix this problem. Codifying the VA's own access standards for primary care services is the means by which we can accomplish this goal.

Secretary Principi and his Deputy Leo MacKay have come before this very committee and testified that the VA has the funds necessary to eliminate wait times. While progress has been made, the fact that nearly 60,000 veterans are waiting longer than six months means there are 60,000 men and women who have served their country who are being underserved by their government.

The Presidential Task Force makes clear in its report ***"that providing sufficient funding to VA will not by its self guarantee timely access to primary care or specialty care appointments."***

Mr. Chairman, the VA is the second largest federal agency. It is appropriated billions of dollars a year to provide healthcare to our veterans. But it is consistently cited by the GAO as an occupant of its "High Risk List" for Fraud, Waste, and Abuse. Clearly, there is room for improvement here!

This legislation will require the Secretary to provide for an outside primary care physician to see the veteran at the VA's expense if the veteran has not been seen within the prescribed access standard. A veteran may elect to wait for his VA appointment if that is his preference. This provision does not apply to geographic service areas that are rated at 90% compliance or higher.

The primary care limitation is necessary because of cost variables and a desire to develop an effective solution to address veterans' needs now, without becoming overly burdensome to the VA. If specialty or ancillary care is needed, the veteran will have to rely on access to VA clinics. However, the ability to immediately diagnose the condition will accelerate the timetable for care and assist the VA in expediting access to those veterans who discover they require immediate medical attention.

Mr. Chairman, codifying the 30 day access standard for primary care appointments is not about the VA, it is not about funding and it is not about Congress. **It is about the veteran.** Failure of Congress to take action on this bill is the equivalent of turning our back on a problem we know is there.

We must not lose this opportunity to bring accountability to the VA. The stakes are just too high.

Opening Statement of the Honorable Cliff Stearns

Committee on Veterans Affairs

September 30, 2003

Mr. Chairman, thank you for holding this hearing today on standards of access in regards to waiting times for a primary care appointment, and also rural veteran access legislation (Rep. Osborne's). My neighboring colleague Rep. Brown-Waite has worked hard to produce this bill, and I am glad we are having a hearing on it today. She represents some of my former constituents, and we share some clinics, and I absolutely understand the frustration we, in fact many or most perhaps, Southern and Western Members feel in hearing about our constituents not getting a clinic appointment for sometimes up to a year. I understand that different VSOs might have different perspectives about this, and I think a healthy debate will ensue today. While we are on the subject of standards of care, I would like to just mention that I am awaiting a response to my July letter to Secretary Principi concerning standards of care for veterans' eye care. Evidently, an Oklahoma-

licensed optometrist has been granted certain laser surgery privileges at the Robert J. Dole Medical Center in Wichita, Kansas. Although this optometrist may be practicing within the scope of her Oklahoma license, Optometrists perform essential, wonderful, professional services to our veterans, but I believe that the practice of permitting non-physicians to perform eye surgery is inconsistent with VA's stated commitment to a uniform standard of care, as part of a uniform benefits package. I look forward to that response, and today's testimony. (And if I may, I will add that letter to the Record as part of my Statement.)

July 18, 2003

The Honorable Anthony J. Principi
Secretary of Veterans Affairs
810 Vermont Ave., N.W.
Washington, D.C. 20420

Dear Secretary Principi:

Like you, I share a deep concern for the health and welfare of our nation's veterans. I write to you today out of that concern, in the hope that working together, we can find a solution to a critical patient safety issue.

I understand that recently an Oklahoma-licensed optometrist had been granted anterior segment laser surgery privileges at the Robert J. Dole Medical Center and Regional Office in Wichita, Kansas. Although this optometrist is allegedly practicing within the scope of her Oklahoma license, I believe that the practice of permitting non-physicians to perform eye surgery is inconsistent with VA's stated commitment to a uniform standard of care, as part of a uniform benefits package. Moreover, it contradicts a published pledge made by then-Undersecretary of Health Ken Kizer in responses to questions from a September 1998 Senate Veterans Affairs Committee hearing, in which he assured both the Congress and veterans organizations that optometrists would not be granted surgical privileges in the VA system.

The substantial difference in the length and depth of training between optometrists and ophthalmologists raises clear patient safety and quality of care issues. Generally, ophthalmologists must complete between 9000 and 12,000 hours of education and training before undertaking unsupervised surgical procedures. My understanding is that the State of Oklahoma has not promulgated any certification rules for optometrists performing anterior segment, refractive, or eyelid surgery. Although Oklahoma has granted laser privileges to optometrists, other states have rejected granting optometrists surgery privileges for the very reasons outlined in this letter.

Over the past several years, the Department has won several awards for its quality of care initiatives. My view is that allowing non-physicians to perform eye surgery would be a step backwards in terms of quality of care, a view shared by veteran service organizations in 1998 when this issue first emerged. Moreover, given the severe resource constraints facing the VA healthcare system, I question the rationale for investing thousands of scarce dollars in a laser surgery system when there are undoubtedly qualified ophthalmologists in the Wichita area

capable of performing needed procedures on a fee-for-service basis, as per existing VA regulations and policy.

Finally, as private sector optometrists in Kansas are barred from performing surgical procedures, the Wichita VAMC exception creates a situation where the federal government is permitting a practice deemed *unsafe* by the Kansas Medical Board and the professional medical community. I am sure you would agree that this is not the kind of standard of care the Department should tolerate.

I believe VA patients are best served by a policy that requires VA facilities to limit optometrists to non-surgical eyecare, as is the case in the U.S. Army today.

Mr. Secretary, in 1998, the Department pledged that for patient safety and quality of care reasons, the VA would not allow optometrists to perform surgical procedures on VA patients, and the VHA Optometry Service Handbook allowing such procedures was rescinded. I urge you to clearly restate and enforce that previous policy decision. You can protect the eye health of veteran patients by ensuring that only licensed ophthalmologists—the only eyecare providers capable of providing the full spectrum of services to veterans—are permitted to perform eye surgery on VA patients. Such an action would send a positive, powerful message that the VA is absolutely committed to providing the best medical care possible to America's wounded warriors.

I would welcome the opportunity to discuss this issue with you directly at your convenience. In the interim, please accept my thanks for both your prompt attention to this matter and your many years of service to our nation.

Sincerely,

Cliff Stearns
United States Representative

CS:les

STATEMENT
LANE EVANS
RANKING DEMOCRATIC MEMBER
COMMITTEE ON VETERANS AFFAIRS
SUBCOMMITTEE ON HEALTH
LEGISLATIVE HEARING ON H.R. 2379 and H.R. 3094
SEPTEMBER 30, 2003

Good afternoon, Mr. Chairman. I want to thank you and Chairman Smith for agreeing to defer the mark up of H.R. 2357 (which has been revised, and is now H.R. 3094) and holding a hearing on the two bills before us today. Each could have significant implications for VA health care programs.

I believe that both of the bills before us have good intentions, but could have unintended side effects for the nation's health care system for veterans. When the gentlelady from Florida brought her previous bill to the Committee's attention, some of us raised concerns about the extent to which this bill would result in mainstreaming veterans into private health care and diverting scarce VA resources away from its medical centers. While I appreciate the gentlelady's revision, these concerns remain.

If conferees accept the House position on funding VA health care for fiscal year 2004, VA will already have to address $1.8 billion funding shortfall—VA programmed $950 million worth of management efficiencies into its budget submission and another $775 million is from the proposals we rejected to increase medication copayments and charge an enrollment fee. The President's Task Force to Improve Health Care Delivery for Our Nation's Veterans shows that VA's per patient costs have declined dramatically since 1992. There is no question that VA is going to be under a lot of duress to make ends meet without the additional mandate of meeting its access goals, however laudable this would be. There is a time when we stop trimming fat out of budgets and start cutting into sinew and marrow. I believe Congress has reached this point with VA health care. In this funding environment, how can we ask them to do more without adding new resources?

Mr. Chairman, last year we were discussing mandatory funding as a remedy to many of the system's woes. I continue to believe that mandatory funding would remedy many of the access problems VA has today. If we gave VA the appropriate funding, it would be appropriate to give it additional

responsibilities with consequences for failing to succeed. However, given the current funding situation, I cannot agree that this is the right remedy for improving access to care for America's veterans.

I am pleased to see this Subcommittee wrestling with the problem of rural veterans' access to care. I represent a rural population and have many concerns about the distances veterans must travel for care. However, I am unsure that the remedy proposed by Mr. Osborne is the right cure. Would the solution for funding impede the efforts VA has made with its allocation system to better match resources to the population served? Would it reward some networks that have been less efficient than others? Would it even help the areas with the highest concentrations of geographically remote veterans? I think the answers to these questions are unclear so I will be eager to hear our witnesses' views on these matters.

Thank you, Mr. Chairman.

Support H.R. 2379
Congressman Charles W. Stenholm
September 30, 2003

I am pleased to support H.R. 2379, the Rural Veterans Access to Care Act of 2003, sponsored by my colleague Congressman Tom Osborne of Nebraska. We live in a land of freedom and abundance, but we sometimes take that freedom for granted. The liberty we enjoy as Americans was won by our veterans and continues to be defended by our nation's military. We owe the brave men and women who have answered this call to duty both a debt of gratitude and compensation for the sacrifices they made.

H.R. 2379 is a good bill designed to help geographically remote veterans that need assistance in covering the long distances between their homes and healthcare facilities. My district, the 17th of Texas, is highly rural, and I know only too well the long distances between cities and towns in my area. Congress must realize that not everyone lives in the city, with amenities at one's fingertips or at the most a few miles away. We may consider a round trip of one to two hundred miles to be nothing, perhaps a time to think and be alone; but what about the elderly veteran for whom the car trip is counted not in terms of peace and solitude, but mile after excruciating mile? What is merely an inconvenience for those of us who are healthy is a seemingly insurmountable obstacle for those who are ill or disabled.

Today, the state of affairs and state of mind for veterans, and especially rural veterans, is one of disappointment, distrust, and disillusionment with their elected representatives. I cannot imagine the sense of disappointment that veterans must feel at the twice yearly parades and pats on the back for Memorial and Veteran's Days, only to witness their access to healthcare cut by the very same people who claim to support them.

In Big Spring, Texas, which is just outside of my district, the VA Hospital is in jeopardy of having services cut and/or eliminated, much to the detriment of rural veterans of the area. I utterly oppose this action. While I understand and support the need to examine and improve the VA healthcare system, it would be unconscionable for us to use a strictly "numbers-based" approach that puts forth the idea that rural facilities service fewer patients, and thus are considered expendable. I reject this notion entirely. Rural veterans deserve the same access as urban veterans, and ostensible improvement to the VA healthcare system should not be done upon the backs of the geographically remote. Having heard from many veterans in my district who cite the hardship of travel to and from healthcare services, and knowing the sacrifices that they made, I am committed to doing what I can to bolster and support the healthcare system that takes care of their needs.

At this time, with our military men and women serving overseas in a hostile environment, we should understand that serving in the armed forces can be a great sacrifice. H.R. 2379 is a small, but important, way of saying "Thank You" to those who made this sacrifice for so many years. We have an obligation to maintain and upgrade the provision of services and benefits to our veterans, who for generations have stepped up to defend our nation, facing difficult challenges and making tremendous sacrifices whatever the circumstances. It is our obligation to make sure that services and benefits meet their needs today, and H.R. 2379 is a proactive and positive step in that direction.

Statement for the Record
In Support of
H.R. 2379, the Rural Veterans Access to Care Act of 2003

Submitted by
The Honorable Doug Bereuter
September 30, 2003

Mr. Chairman, I express my strongest support for H.R. 2379, the Rural Veterans Access to Care Act for 2003. Indeed, I am a proud co-sponsor of this measure which was introduced by my colleague, the very distinguished gentleman from Nebraska (Mr. Osborne). He is to be commended for crafting this legislation which addresses a critical problem about which our constituents in Nebraska are increasingly expressing their concerns.

For many years, I have been far from satisfied with other various actions of the U.S. Department of Veterans Affairs, such as: (1) the use of the health care allocation formula instituted by the Clinton Administration and continuing to this day, which in effect penalizes veterans living in sparsely settled states like Nebraska; (2) the reorganization of the Nebraska-Iowa region into a larger region headquartered in the Twin Cities of Minnesota; (3) the end of in-patient hospitalization in the Lincoln and Grand Island VA hospitals; and (4) the current procedural difficulties for veterans to have prescriptions filled.

In total, these faulty decisions have amounted to discrimination against veterans in rural areas. First, due to the closure and consolidation of veterans health care facilities in Nebraska, veterans in rural areas frequently must travel several hours simply to receive the basic services for which they are eligible. As a result of this travel, they must incur transportation costs such as overnight accommodations which other veterans are not expected to incur for the same services. Furthermore, requiring elderly and frequently sick or incapacitated veterans to travel on Interstate 80 and other very busy roads and highways is not only unfair to them but it also places them and other citizens at risk.

Through H.R. 2379, no less than 5% of the total appropriated funds for veterans health care would be dedicated to address veterans health care access problems in highly rural or geographically remote areas. (As amended by this bill, "highly rural" or "geographically remote" would apply to areas in which veterans have to drive 60 minutes or more to a Department of Veterans Affairs (VA) health care facility.) Each Veterans Integrated Service Network (VISN) director would receive an equal level of funding from this account and then have the discretion to address rural access issues as best fits each VISN. If a VISN would be unable to use all of the funds from this account, the VISN would not be allowed to retain unused funds. Instead, the Secretary of Veterans Affairs would then have the opportunity to reallocate those funds to other VISNs solely for highly rural and geographically remote areas.

Mr. Chairman, as you know, it is simply not true that the Federal Government is cutting back on financial support for veterans' health care or that Congress or our recent presidents aren't supportive of veterans. Each year, Congress sets new records on the amount of appropriations for veterans' health care. This is not only because of higher health care costs but also because we have more and more veterans who are of the age where they require additional and costly medical care, including many WWII and Korean War veterans plus a very large number of Vietnam War and other veterans. As you undoubtedly know, during 2002 approximately 4.7 million individual veterans received VA medical care. Outpatient visits are increasing rapidly, with 43.8 million visits last year. Both the general VA inpatient caseload and acute care cases are also increasing, with the daily inpatient caseload projected to be over 57,000 and the acute care up 2,700 over last year. Yet thousands of veterans are on waiting lists for medical care, after waiting months for appointments to see medical staff.

Between FY1998 and FY2003, the total appropriation for the VA has increased 41 percent, an increase greater, of course, than the average increase of Federal domestic programs. The appropriation for VA medical care in FY2003 jumped to $23.8 billion -- $1.1 billion more than the president's request. Each year, the president asks for a far larger increase than in almost any other domestic program, and each year the Congress exceeds that request. Indeed, in his budget request for FY2004, the president has requested $25.2 billion for VA medical care.

I regret to say that despite these increases, there have been cutbacks in the access veterans in rural areas have to adequate health care while there have been advances in other geographic areas. Mr. Chairman, the health care needs of our military veterans must be met to the fullest extent possible. Veterans fought to protect our freedom and way of life. As they served our nation in a time of need, the Federal Government must remember them in their time of need. The debt of gratitude the people of the U.S. owe our veterans surely means that we should assist the veterans where such need exists.

I am committed to ensuring that Nebraska's veterans receive the benefits they deserve; benefits they had expected and which I believe the American people want to deliver. I urge this Subcommittee and ultimately the House Veterans Committee to take favorable action on H.R. 2379 and thus take a critical step toward assisting veterans in the sparsely served areas of our country which are far from veterans health care services.

Thank you.

Statement of Representative Tom Osborne (R-NE)
Before the
Subcommittee on Health
House Committee on Veterans' Affairs
H.R. 2379
"The Rural Veterans Access to Care Act of 2003"
September 30, 2003

Mr. Chairman and Members of the Committee, thank you for holding a hearing on H.R. 2379, the Rural Veterans Access to Care Act. I appreciate the Committee providing me with the opportunity to testify about the health care needs of rural veterans. I would like to complement the Chairman for his leadership on this very important issue.

In 1995, the Department of Veterans Affairs (VA) changed from a system of providing hospital care for veterans to one that provides comprehensive medical care through primary care physicians at outpatient facilities. The changes resulted in Community Based Outpatient Clinics being established in Nebraska, and it consolidated VA hospital services in Omaha, Nebraska; Cheyenne, Wyoming; Denver, Colorado; and Hot Springs, South Dakota. I have a map of Nebraska which outlines the VA medical facilities in Nebraska. The only VA hospital is the one in Omaha. There is a VA medical facility in Grand Island and seven Community Based Outpatient Clinics in Lincoln, Norfolk, North Platte, Sidney, Alliance, Rushville and Gering. The VA hospital in Grand Island, which is in my district, changed its mission from hospital care to an outpatient clinic. Although I recognize that the VA has changed its mission to provide more points of access for veterans, many rural veterans in my district are still left driving extraordinary distances, often through extreme weather conditions for routine check-ups or tests.

I would like to introduce Arthur Johnsen from Holdrege, Nebraska, who will be testifying today. Art is a Vietnam Veteran and Veterans County Service Officer for Phelps, Harlan and Franklin Counties in Nebraska. Art knows first hand what it is like for geographically remote veterans to travel extreme distances. When Art needs to go to the VA for a routine check-up, he has two options: either drive 100 miles to Grand Island or drive 100 miles to North Platte. Either way, it will take him two hours in normal weather conditions, and much longer in the treacherous driving conditions that often mark Nebraska winters. Art also has to calculate the time spent waiting for his appointment, the time needed to see the doctor, and the time it would take for any routine test that the doctor decides he needs. When you calculate the time, Art will miss one day of work to have routine medical services performed by VA, when those services could much more efficiently be given to him by providers near to where he lives.

I know what it is like for these veterans, because the Third Congressional District encompasses 64,000 miles, and I've driven most of them. Now compare that to the total mileage veterans in Veterans Integrated Service Network (VISN) 23 travel. The VISN 23 service area exceeds 390,000 square miles which includes Iowa, Minnesota, Nebraska, North Dakota, and South Dakota and portions of the states of Illinois, Kansas, Missouri, Wisconsin, and Wyoming. Veterans in VISN 23 are traveling thousands of miles in extreme weather conditions for routine medical care.

What kind of extreme weather conditions are geographically remote veterans in Nebraska traveling through? According to the National Oceanic and Atmospheric Administration, for the past three years, Nebraska has averaged nine winter storms per year and has averaged 53 individual tornadoes per year. On average, Nebraska has about 1,000 reports of severe weather from thunderstorms each year. Our veterans are currently driving through these storms to get the care they need.

At each stop I make in my vast district, veterans like Art Johnsen continue to express to me their concerns about traveling hours for routine medical care. I looked at various options to address this problem, and I developed H.R. 2379, the Rural Veterans Access to Care Act.

Under current law, and the practices that VA uses to allocate funds among its 22 VISNs, facilities are discouraged from using funds for reimbursing of medical services provided to veterans outside of VA facilities. H.R. 2379 would encourage VA to more frequently use its authority to contract for routine medical care with local providers for geographically remote veterans who are enrolled in the VA.

How will the funding be used? The VISN director will use the funding for acute or chronic symptom management; non-therapeutic medical services; and other medical services as determined appropriate by the director of the VISN after consultation with the VA physician responsible for primary care for the veteran.

H.R. 2379 sets aside five percent of the appropriated VA medical care allocation to be used for routine medical care for geographically remote veterans. If five percent were taken from the current medical care account, a little over one billion dollars would be available to distribute among the 22 VISN networks to provide routine medical care for geographically remote veterans. How much would that be per VISN? It figures out to be over $55 million in VISN 23 for the treatment of geographically remote veterans. If VISN 23 has 90,000 geographically remote veterans, the VA would have available per veterans average of over $600 each year to provide each of these primarily rural veterans routine medical care from the providers in their communities.

Each VISN would receive the same percentage of funds to be used for rural or geographically remote veterans. If the money is not used by a specific VISN during a fiscal year for geographically remote veterans, the funding will be made available to similarly situated veterans in other parts of the country. That VISN is at risk for a reduced total allocation in the following budget cycle. But it will still be required to set aside five percent for Rural Veterans Access to Care in the subsequent year. During the current year, the VA could make unspent rural access funds available to similarly situation veterans in which the allocation is not being exhausted. The legislation gives VA the authority to transfer the allocated funds not used by a VISN to another service region or regions to be used for routine medical care for geographically remote veterans.

According to an August 2001 report by the Department of Transportation, the risk of accidents by older drivers increases when they drive longer distances, have a change in physical abilities and if they have certain medical ailments. It is estimated that about 10% of older drivers have medical conditions that may lead to unsafe driving behaviors.

Some critics may say that this legislation will harm the VA health care system. I disagree. The legislation does not take funding away from the treatment of veterans, but it provides the VA with an incentive to provide enhanced care to rural veterans.

How does the legislation define geographically remote? H.R. 2379 provides a basis determining which veterans would be eligible for the bill's provisions, but the VA will make the final determination as to the medical services that would be provided under contract to local medical providers.

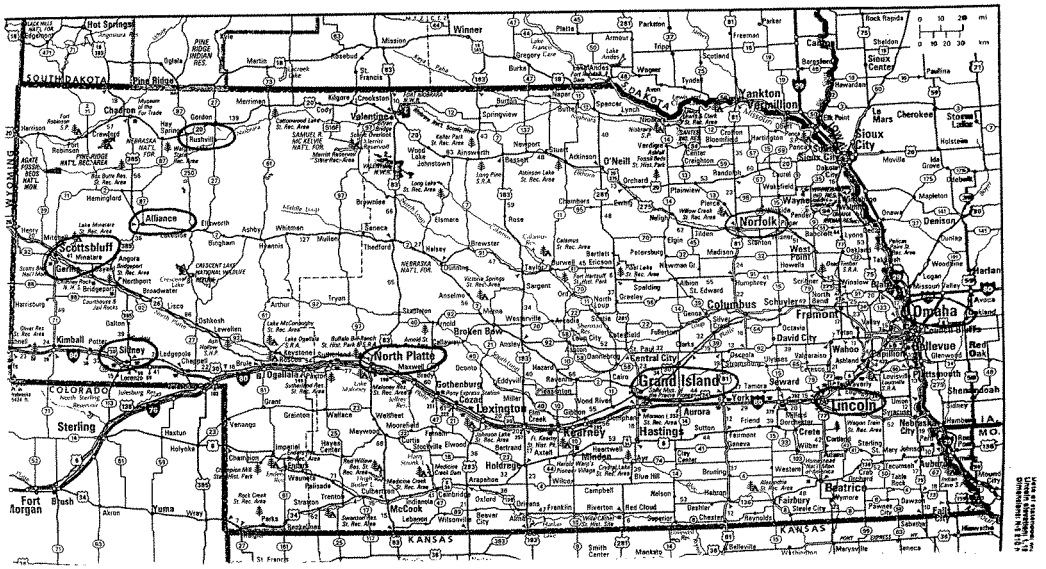
There are a number of advantages to providing local medical services to geographically remote veterans. The veterans would be able to access health care in a more timely fashion, instead of waiting six months to one year for an appointment for routine medical care. The geographically remote veterans would also be closer to their health care providers, rather than traveling hundreds of miles for an appointment at the VA, which could be an especially dangerous trip during inclement weather.

Contracting locally for health care for enrolled veterans would also benefit the rural communities that would provide these services. Many rural communities are struggling to maintain health care systems, as their caseloads are often insufficient to provide adequate revenue for clinics to remain financially stable. Adding these veterans to their caseload would provide an additional stable source of revenue to these financially strapped clinics.

I also would like to point out the lower cost of contracting care in rural areas. According to the VISN 23 CARES market plan, the cost to contract for care with a local medical provider would be under $500 thousand a year in O'Neill compared to leasing a facility that would be staffed by VA employees. For the Holdrege facility, it would be almost $1 million a year. I am pleased the VA is reviewing the cost of contracting and comparing it to leasing a facility and staffing it with VA employees in rural areas of the United States that have medical facilities already available for veterans.

Once again, I would like to thank the Subcommittee for the opportunity to appear before the Subcommittee as it considers H.R. 2379, the Rural Veterans Access to Care Act. I believe it would be more effective and efficient to provide routine medical services at a local level, and I believe this legislation addresses this very important issue. I also believe that it is important for us to consider the hardships that our veterans have faced while serving our country. The older men and women among them are in the twilight of their lives and need medical services that can be provided closer to home. Many of them made huge sacrifices on our behalf to defend our great country and I believe it is time that we improve their access to health care. Again, thank you for giving me the opportunity to provide my testimony on H.R. 2379. I would also like to thank Dr. Dennis Snook, of the Congressional Research Service for invaluable assistance to my office as we developed this bill.

Department of Veterans Affairs
Medical Facilities
in
Nebraska



September 30, 2003

Opening Statement by Congressman Jon C. Porter
House Committee on Veterans Affairs
Rural Veterans' Access to Care Act – HR 2379

Thank you, Mr. Chairman, for holding this hearing and for your leadership on this issue. Ensuring access to health care for veterans in rural areas is essential to keeping our promise to the brave men and women who have served our country.

I look forward to the evaluation of HR 2379 this afternoon. I am proud to be a cosponsor of this bill and look forward to working with Chairman Simmons and Congressman Osborne on its swift passage. This legislation would greatly improve access to medical services for veterans who reside in rural areas. The same high quality care must be provided for veterans living in both rural and urban environments. It is our duty to show our appreciation to those who have sacrificed so much for our great nation.

More than 240,000 veterans reside in my home state of Nevada. I would first like to take the opportunity to thank Secretary Anthony Principi and the Department of Veterans Affairs (VA) for their recent proposal to expand health care services for veterans in Southern Nevada. I was excited to join Secretary Principi in announcing the VA plan to build a full-service hospital in Las Vegas that will become the centerpiece of a major expansion in health services for veterans in Southern Nevada. For many years, veterans in Southern Nevada have indicated the importance of such a facility, and I have agreed with them and worked towards securing an appropriate facility. In addition, I strongly support the VA recommendation to establish a new nursing home in Southern Nevada. These proposed facilities would help to meet the varied health care needs of our veterans.

Unfortunately, many veterans residing in rural communities in Southern Nevada face exceptional hardships from a lack of accessible health care. While many veterans live in cities such as Las Vegas, Henderson, and Reno, veterans who prefer to reside in smaller communities should not be forced to sacrifice their health benefits.

In my home district, in Laughlin, Nevada, patients must drive approximately 200 miles round trip to receive their healthcare services in Las Vegas. During much of the year, high temperatures in the Mojave Desert combined with congested infrastructure make travel difficult and dangerous for older veterans. Approximately 1,400 veterans from the Laughlin area visited the VA Southern Nevada Healthcare System for VA healthcare in 2002. This number does not include veterans who forego receiving primary medical care essential for maintaining general good health because of difficulty accessing VA facilities. Currently more than 17,000 veterans reside in the rapidly growing Laughlin, NV area. Increased funding for rural health care would reduce travel difficulties and shorten waiting times for these veterans in need of outpatient health care. While I have illustrated some of the difficulties faced in my home state of Nevada, I am certain the veterans across the United States face similar issues.

I look forward to working closely with the Department of Veterans Affairs and the Secretary of Veterans Affairs, the Honorable Anthony Principi, to ensure that veterans in the rural areas of Southern Nevada and across the nation are provided the best possible health care.

Again, I thank Chairman Simmons and Congressman Osborne for bringing attention to this important issue and I appreciate the committee's work on this legislation.

Statement of Arthur L Johnsen
County Service Officer for Phelps/Harlan/Franklin Counties in Nebraska
Before the Subcommittee on Health
Veterans Access to Timely Healthcare
September 30, 2003

Let me begin by taking this opportunity to thank the chairman and the committee for allowing me the honor of testifying before this sub committee. I would also like to commend each of the committee members for their service in overseeing the important issues affecting our nations veterans.

I will begin my testimony by informing the committee of the distance that the veterans I serve have to travel. It is about 90 miles one way to the Grand Island Veterans Affairs (VA) Medical Center and 100 miles one way to the North Platte Community Based Outpatient Clinic (CBOC). This means that the veteran wanting to access VA health care will spend three and one half to four hours of driving time depending on the route traveled and the road conditions. The time spent in the facility can be two or three hours easily. Thus total time spent including travel time for a veteran can easily be seven to eight hours. The above holds true if the veteran is seen within 30 minutes of their scheduled appointment, which at the Grand Island facility is usually the case. As you can tell the process takes a full day for the veteran to receive primary health care.

The above scenario is set in a sequence of events that unfold in a favorable fashion for a veteran that is self sufficient, owns a vehicle, and can afford to lose a days pay. However this type of veteran is in the minority. The majority of my veterans that are seeking VA healthcare are World War II and Korean veterans. The veterans of this group are finding it increasingly difficult if not impossible, to travel 180 to 200 miles round trip for healthcare.

There are other barriers our veterans have to try to overcome just to access VA healthcare. In our mid-western and plains states we have extreme weather conditions both winter and summer. This forces our veterans and their wives to be traveling in weather conditions that are possibly hazardous to the health and well being of both parties. Also, harvest is fast approaching and this will mean increased slow moving farm machinery and grain trucks on our secondary highway system. Many of our veterans use the secondary highways because they feel unsafe on interstate 80 due to the volume of semi truck traffic and the speed at which they travel.

We also have another growing group of veterans that fall into the following category. They are men and women who due to age or infirmity cannot drive themselves. Therefore they are dependent on family members. This usually falls to the children. The problem with this is that the children do not live near their parents in fact most live out of state, due to the lack of high paying jobs located in the rural areas of our state. This veteran is faced with a dilemma, how does he access VA healthcare? Many veterans are unable to make their appointments because they can't travel. They resort to cutting their pills in half to extend their supply to avoid running out before they can some how make it

to the VA facility for their next appointment. One of my veteran's daughters lives in North Platte which is 110 miles from her parents home. This lady makes 2 full round trips each time her father has an appointment at the North Platte CBOC. He has recently suffered a heart attack so I am sure his frequency of appointments will increase and her time away from her family will increase.

My question is what is going to happen to the ever increasing number of veterans that have no family members to assist them with their healthcare issues and how do they travel in excess of 200 miles when they are ill?

Other veterans are forced to use the VA van system from North Platte to Grand Island and then on to the Omaha VA Hospital. A veteran that uses the VA van system for an appointment at the Omaha VA Hospital will probably have a travel schedule like the following example: the round trip from North Platte to Omaha will usually take four days and three nights. The Grand Island VA Medical Center has had the following services moved to the Omaha VA Hospital: surgery, dialysis, cataract removal, plus the administrative decisions for the Grand Island Medical Center were transferred to Omaha. This decision has made it difficult to get timely answers to perplexing questions in a timely manner. The Grand Island VAMC also closed the in-patient services, ICU, and the emergency room. Because of these closures, the VA has been furnishing lodging and meals. At our last VA Update at the Grand Island VAMC it was announced that lodging and meals were no longer going to be provided. This action is forcing the veteran who is least able to afford these expenses to choose between receiving healthcare and paying lodging bills or staying home and doing without healthcare. Our rural veterans can not absorb these types of expenses because it would force an undue financial hardship on the veteran and their family. At the time of the announced cutback in services at the Grand Island facility the county veteran service officers were told not to worry, the VA would make sure that our veterans would have access to the services they need. By eliminating the lodging and meal benefit to the veterans that are dependent on this mode of transportation, the VA has eliminated their access to healthcare

With these closings, there has been a contract in place with St. Francis Medical Center. It has been my observations that my veterans in need of hospitalization are transported to the Omaha VA Hospital instead of using the contract facility close to their home and family. The veterans that live in and close proximity to Grand Island and are currently enrolled in VA healthcare have access to the emergency room at St. Francis Medical Center. Those veterans living outside the Grand Island area either have no VA Emergency Room access or must travel to Grand Island to receive ER care and trust to luck that their condition doesn't worsen before they arrive in Grand Island.

The location of the Omaha VA Hospital poses significant hardships on the veteran and their families. The following are some examples of these hardships. I have a veteran that resides in one of the counties that I serve. In the past 18 months this veteran and his wife have had to travel in excess of 40,000 miles for VA healthcare. As a result, the family's savings have been depleted. The veteran is still being sent to Omaha for chemotherapy treatments and the miles and the expenses keep adding up for this family.

Another example of the difficulties faced by our veterans is obtaining hearing aids. This requires two or three round trips to the Omaha VA Hospital, which means these veterans, travel 900 to 1350 miles for their hearing aids.

Then there are the issues of timeliness for new enrolled veterans. One aspect of timeliness is the length of time that it takes to get an appointment to be seen by a VA healthcare provider. Secretary Principi has set a 30-day timeline for veterans to be seen if they are 50% service connected or greater. This would put the veteran in Priority Group 1 and to the best of my knowledge Grand Island VAMC is meeting the secretary's goal. I believe they are doing a fine job of scheduling the Priority Group 1 veterans. However, the veterans that are in priority groups 2 thru 8 are a different matter. The veterans that are newly qualified to access VA healthcare such as an initial service connected rating, a new pension rating, or a change in financial status have to wait up to five months for their first appointment with a VA physician.

This then brings us to the second part of the timeliness issue. That would be timeliness of care of veterans already enrolled in the VA healthcare system. The veteran reports to the Grand Island VA Medical Center in March of 2003 with rectal bleeding. The VA physician schedules a colonoscopy for the veteran and tells him to go home and he will be contacted with the scheduled date of the procedure. The veteran receives word shortly after he returns home. The procedure has been scheduled for September 10th, 2003. This is a 5-month waiting period for this veteran to receive the procedure. This veteran was lucky there was no malignancy found. I ask that you put yourself in this veterans place. Would you feel comfortable waiting five months to get the results from this procedure before you knew for certain that you did not have cancer, I think not, I know I certainly would be worried not knowing for five months. In the private sector this procedure is not a specialty clinic it is handled as an outpatient treatment and done in the doctors office. The patient is in by 7:00 A.M. and back home before 9:00 A.M.

The final example I will use deals with both access and timeliness. The veteran suffered a heart attack in Holdrege Nebraska. He was stabilized and the VA ambulance picked the veteran up and transported him to the St. Francis Medical Center in Grand Island Nebraska. He was seen by a physician that told him they could not care for him at this facility and he would have to be transported to the Omaha VA Hospital. This transfer took place the next day. Upon examination he was told that he was not an emergency but that he would need open-heart surgery. It would have to be done at the Minneapolis Minnesota VA Hospital. This veteran was told to go home and he would be contacted with the information and date of his surgery. The scheduled appointment was in excess of five weeks from the date that he had his heart attack. The wife of the veteran wanted to accompany her husband to the hospital and be there for him when he came out of surgery. The VA would fly the veteran to Minnesota but not the spouse. The veterans wife eventually had to have her brother drive them from south central Nebraska to the Minneapolis VA Hospital. I would like to inform the Subcommittee on Health that the examples I have set forth in this testimony are not isolated incidences but depict what I believe to be an accurate picture of the healthcare issues faced by our rural veterans.

I would like to address how rural veterans are being considered in the Capitol Asset Realignment for Enhanced Services (CARES) Initiative. I was approached to serve on the CARES Area Market Planning (CAMP) Team. I was told that one of the primary functions was to improve primary care access for all veterans with a goal of having a CBOC within 60 miles of a veteran's home. I gladly accepted the offer to serve on the Grand Island VAMC CAMP Team. When we started in December of 2002 we were furnished data on all the facilities, current number of veterans, projected number of veterans in 2012, and projected number of veterans in 2022. Of course the numbers did not take into account the war our young men and women are involved in at the present time. However we worked with the information provided to us and came up with our recommendations. Our plan included improvements to the Grand Island VAMC to better serve the rural veterans. In these plans CBOC's and contracting with local physicians were both going to be used and those that were already in existence were going to be able to increase the number of veterans that they were providing services to. We completed the CARES CAMP Team process and submitted the plans to the CARES Commission.

The CARES Commission released a draft plan and to my shock and disbelief the Nebraska clinics were pushed down to priority two. In other words, we might be considered for these clinics in 2007 and beyond. The reason I say "shock and disbelief were my reactions" is because the information that was provided by the VA for us to work with shows the Holdrege Nebraska CBOC would serve 6776 veterans through 2012. Then from 2012 through 2022 the site would serve 6136 veterans. I believe the purposed number of veterans being served at the Holdrege Nebraska site is larger than many sites already in existence at this time. As the CAMP Team was to learn, the reason that the states of Nebraska, North Dakota, and South Dakota did not receive much consideration from the CARES Commission was that the total population of the states fell below their guidelines. Many of us on the CAMP Team pointed this out from the start: the process is punishing the rural states and we never would qualify for favorable recommendations from the Cares Commission.

In preparation for this testimony, I met with my hometown physicians and asked them if they could handle an increased patient load with the same number of veterans as the CBOC was going to care for. Their answer was yes, and they believed that in the long run they could provide quality healthcare with less expense to the government. One physician is quite certain that the redundancy that would be taken out of the system on a nation wide basis would be a great dollar savings to the government. He believes that with contract facilities the quality of healthcare would go up due to the continuity of service and cooperation between the VA and the private sector physicians.

Also I am pleased to inform the committee that I receive very few complaints about the quality of the VA Healthcare. I have also witnessed a change of attitude within the VA that was not there in the past; the veteran is being treated with greater respect than before. I believe this is due to the VISN 23 Director, Dr. Robert Petzel and he should be commended for the changes and improvements that he has initiated within VISN 23.

In closing, I thank the Subcommittee on Health for their time and urge them to strongly support H.R. 2379, Rural Veterans Access to Care Act of 2003 Introduced by Honorable Tom Osborne and H.R. 3094, Veterans Timely Access to Health Care Act introduced by Honorable Ginny Brown-Waite

Committee on Veterans' Affairs
Health Subcommittee Hearing on
The Veterans Timely Access to Health Care Act
09/30/2003

John J. Kenney, VSO Officer
Citrus County, Florida

Good Afternoon Mr. Chairman and members of the subcommittee. I'd like to thank the Chairman and Congresswoman Ginny Brown-Waite for the opportunity to come before this subcommittee to provide testimony on the issue of timely access to VA Health Care. This is by far one of the most important issues to our veteran population and particularly our aging World War II and Korean Veterans. This is a national problem but as a VSO officer in the state of Florida, a state which has the second largest veteran population and the oldest veteran population, the problem of access to VA health care is acute.

Please allow me to provide the subcommittee with some back ground information on the plight of Florida veterans from the vantage point I have as a Veterans service officer in Citrus County. Here we have a veterans' population of over 24,000. Prior to the year 2000 there was no VA Primary Care available in Citrus County. Fortunate veterans traveled 45 minutes to Ocala to receive care. However, the majority of those seeking primary care had no choice but to travel an hour and a half north to VAMC Gainesville for care. Others traveled over two hours south to either James Haley VA Medical Center in Tampa or Bay Pines VA Medical Center. Many of these men and women were elderly, having served their nation during World War II and Korea and had to relay on friends, family, or their fellow veterans to meet their travel needs.

To our great relief, the VA opened the Community Based Out-Patient Clinic in Inverness, Florida in July 2000. A mass enrollment was conducted and everyone, including myself, was shocked by the overwhelming numbers. Remarking on this, a VA Staff member observed, "Build it and they will come", and come they did. In addition to those enrolled at that time our Citrus County Veterans Service Office has processed 1,768 10-10 EZ Application for Health Care as of 26 September 2003. Almost immediately after opening its doors, veterans seeking care at the Inverness clinic were being told it would be **over a year** from the time of enrollment before they

would receive Primary Care. If the veteran had an immediate problem he or she was instructed to make the drive to Gainesville to be seen at Urgent Care Clinic where they could be seen for the specific malady but would not be assigned a Primary Care Team.

The patient load for the Inverness clinic as of 25 September 2003 is 3,948. Care for nearly 4000 veterans is spread between three doctors with an average patient load of 1,316.

New enrollees can look forward to the following wait times:

Veterans rated at 50% Service Connected or higher are being seen within 30 days per the direction of the VA Secretary.

Veterans rated at 0% to 40% Service Connected are receiving appointments within 90day.

Non-Service Connected Veterans with urgent medical needs receive their appointments within one week to 90 days.

Non-Service Connected Veterans without any major medical problems can look forward to up to 180 days before receiving their first Primary Care appointment.

With the exception of service connected veterans rated at 50% or higher, these wait time are unacceptable. A delay in health care between 90 and 180 days would be unacceptable for every member on this committee and it is just as unacceptable to tell a veteran this is the best you can do.

When I received my invitation to appear before this subcommittee I had members of our Veteran Service Team conduct a random review of the enrollment forms for Primary Care from January 2001 through June 2003. The longest wait time was 33 months the shortest 1 month. We found several veterans seeking primary care who applied in 2001 who had never heard back from VA. It was verified that they were enrolled in the system but for one reason unknown they had not been scheduled for a primary care appointment. Upon notifying the clinic they have been tentatively scheduled for November. I have copies of our review available for members of the Committee.

The news about wait times was even worse in Gainesville. Many veterans are waiting through backlogs in Audiology and the eye clinic. The current backlog at audiology is 2,540 veterans. These types of backlogs will only increase as our veteran population continues to grow.

Staffing continues to be a contributing factor to the wait times for Primary Care. Until the VA is able to recruit and retain sufficient numbers of permanent care givers this will continue to impact on the timeliness and quality of care that our veterans are deserving of.

HR3094 the Veterans' Timely Access to Health care Act provides some relief for the timely receipt of health care for our veteran population. By mandating that each veteran must be seen within the 30-day VA access standard Congress would be accomplishing three very important things.

First and foremost you are insuring that those who have served this great nation receive the type and quality of care they deserve. Second, you are showing those who are currently serving in the United States Armed Forces as well as future Marines, Sailors, Soldiers, Airman and Coast Guardsman that we as a nation are mindful and grateful for the sacrifices made by the men and women of the armed forces. Third and finally, I believe it will make the Department of Veterans Affairs more efficient. No organization wants to pay for services that they are quite capable of providing themselves.

I believe that VA is currently making significant strides towards improving the quality and accessibility of VA Health Care. There is also improved utilization of financial, personnel, and fixed assets through the CARES Program. Which is underway. I applaud the Secretary's accomplishments.

VA will better service those men and woman who have honorably served their nation by clearly identifying the areas of need and realignment of assets to meet demand. This legislation will enable the Department of Veterans' Affairs to accomplish the mission a grateful nation charged them with- to provide timely and adequate healthcare to veterans.

HR3094, in my opinion is a good piece of legislation. I believe it will positively contribute to the continuing improvement in the VA Health Care System.

Thank you Mr. Chairman and members of the Subcommittee for granting me this opportunity. I am honored to be able to address such a distinguished group of public servants.

STATEMENT OF
ROBERT H. ROSWELL, M.D.
UNDER SECRETARY FOR HEALTH
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
UNITED STATES HOUSE OF REPRESENTATIVES
SEPTEMBER 30, 2003

Good afternoon Mr. Chairman and Members of the Subcommittee.

I am pleased to be here this afternoon to present the Administration's views on two bills, H.R. 2379, the Rural Veterans Access to Care Act of 2003, and H.R. 3094, the Veterans Timely Access to Health Care Act. The sponsors of both bills have introduced the measures in an effort to improve access to VA health care facilities by certain veterans. However, we believe both bills, if enacted, will actually be harmful to existing efforts to improve access to VA care. We strongly oppose both measures.

H.R. 3094

Mr. Chairman, I will begin by discussing H.R. 3094. This bill would establish a 30-day standard as the maximum length of time that a veteran would have to wait to receive an appointment for primary care in a VA facility. It would also direct that we establish a standard for the maximum length of time that a veteran would have to wait to actually see a provider on the day of a scheduled appointment. If the Secretary finds that any particular VA geographic service area fails to substantially comply with the time standards, facilities in that area would have to contract for the care of a veteran in each instance that they are

unable to meet the standards. The contracting requirement would be mandatory for veterans who are within enrollment priority group 1 through 7, and discretionary for those within priority group 8.

To determine whether geographic service areas substantially meet the time standards for access to care, the bill would require the Secretary to carry out a one-time examination of waiting time data for the entire system, segregated by geographic service area. The review would be of data for the first quarter of the calendar year after enactment of the bill, presumably January, February, and March of calendar year 2004. By July 1st of the same year, the Secretary would have to issue a determination regarding compliance with the standard in each service area. If the compliance rate for any area is below 90 percent, then facilities located in that area would be subject to the requirement that they contract for care whenever they are unable to meet the standards.

The bill would also require that we submit two reports to the Committees on Veterans' Affairs of the Congress. The first would be an annual report providing an assessment of our performance in meeting the timeliness standards. The second report, however, would have to be made quarterly, and would have to include very detailed waiting-time data for each geographic service area. The bill would require these quarterly reports to include the number of veterans in each geographic service area waiting for care, distinguished by primary care and specialty care. It would require the data to be broken down by length of waiting time distinguishing between those waiting under 30 days, 30-60 days, 60 days to 4 months, 4-6 months, 6-9 months, over one year and those who cannot be scheduled at all. The quarterly report requirement would continue through the year 2010.

Mr. Chairman, in our view, H.R. 3094 has the potential for dramatically increasing demand for VA care, overwhelming our ability to provide care in VA operated facilities. At this point in time, we don't believe any of our VISNs would

be able to comply with the 30-day standard for 90 percent of patients seeking primary care during the first quarter of 2004. Thus, if the bill were enacted, every VA facility would be forced to offer veterans desiring a primary care visit, the opportunity to receive that care in the private sector on a contractual basis. We believe that huge numbers of veterans who now choose to receive their primary care in the private sector would likely avail themselves of this new benefit. That is particularly the case with veterans who have significant out-of-pocket costs in the private sector, or limitations on the availability of prescription medication. This enhanced demand would have the effect of draining appropriated funds out of VA operated facilities to pay for contract care, potentially requiring that we further curtail enrollment in the VA system.

As you know, it is quite common for a primary care physician to refer a patient to a specialist for further examination or treatment. Physicians seeing patients on a contract basis under this bill would have to refer those patients to a VA physician specialist unless a particular veteran is eligible for fee-basis care in the private sector. Most of these veterans would not be eligible for such fee-basis care. We would anticipate that the increased demand for primary care generated by the measure would dramatically increase demand for specialty care. That would further exacerbate waiting time problems in VA, generate complaints from veterans seeking more timely specialty care, and potentially require further curtailment of enrollment. The Administration preliminarily estimates that the increased demand for VA health care resulting from enactment of the bill could run into the billions.

Another serious flaw in this bill is that it would require VA to trigger the contracting requirement based upon a one-time snapshot of waiting times in the

VA system, presumably during the first quarter of 2004. The bill provides no mechanism for the reassessment of a geographic service area, or for the termination of the special contracting authority.

The bill does not differentiate between an initial primary care appointment and a follow-up appointment, which may be scheduled based on the provider's judgment. The bill makes no allowances for clinical appropriateness of or need for a primary care appointment within 30 days. It also does not take into account patient convenience or agreement.

Although the bill is not precisely clear on the matter, it appears to direct that we create a standard for the length of time a veteran would have to wait to see a provider on the day an appointment is scheduled, and require contracting for care when we are unable to substantially comply with the standard. The rationale for this is unclear to us. Waiting times on the day of appointment are better addressed through performance measures than through a standard arbitrarily designated in law or regulation. We would not turn away a patient because he or she had to wait 40 instead of 20 minutes because of the attention needed by the provider to treat a patient with an earlier appointment or to respond to an emergency situation. Unanticipated delays while waiting to see the provider are not unusual in the health care arena. It is also not clear how the day of service standard would or could be implemented or satisfactorily monitored.

We anticipate the Department would have tremendous difficulty implementing many provisions of this bill, particularly in the required time frames. The assessment of the VA system early next year would be difficult to achieve, and the reporting requirements imposed by the bill would be quite onerous. In many locations, shortages of providers may make it difficult to carry out the contracting requirements the bill would impose. We would also expect to face difficult issues associated with patient medical records as a result of the

fragmentation of care between VA and the private sector that the bill would foster.

As you know Mr. Chairman, in recent years we have faced unprecedented new demand for services. Unfortunately, we have been unable to provide all enrolled veterans with services in a timely manner, and we have been forced to place many veterans on wait lists. However, significant progress is being made on reducing these wait lists. Just over a year ago we had over 300,000 veterans waiting 6 months or more for an appointment. Today, this number is under 60,000. We have established strategic goals to achieve the level of timeliness indicated in the bill and we expect to reach those goals with your help. However, enactment of H.R. 3094 would only make that effort more difficult.

H.R. 2379

I next turn to H.R. 2379. This measure would require that beginning with fiscal year 2005, we must make not less then 5 percent of all funds in the Medical Care appropriation available to improve access to medical services for veterans in highly rural or geographically remote areas. The bill would require that we spend the funds to increase access by making greater use of our authority to contract for the care, as well as by using other authorities. Initially, we would have to allocate the set-aside funds equally among all of our geographic service areas, but the Secretary could subsequently reallocate the funds from areas that will not use all funds initially made available. After three years, the Secretary could recommend that Congress adjust the overall percentage of set-aside funds, as well as the percentage of the funds to be made available to each service area.

The bill would require that we promulgate a regulation defining what we consider as a highly rural or geographically remote area so veterans living in the area would benefit from the set-aside. However, the bill would provide that at a

minimum, the definition would have to include any area where the driving time to a VA health-care facility exceeds 60 minutes.

As I stated above, we cannot support this measure. Mr. Chairman, VA has developed a very sophisticated methodology for allocating appropriated funds throughout our system in the fairest way possible. This measure would be very disruptive to that allocation system and be unfair to veterans in other parts of the country.

We also have very serious concerns that the bill could result in significantly increasing our non-VA health care expenditures by essentially forcing VA to increase the number of veterans receiving such care. Often such care is much more expensive than care VA furnishes directly. Moreover, to some extent, this would encourage significant additional demand on our already limited resources due to an increase in the number of veterans attempting to access health care through VA. That could be deleterious to our efforts to reduce already unacceptable waiting times for appointments. We certainly do not want to find ourselves in the unwelcome position of disenrolling veterans in Priority Group 8, and possibly stopping the enrollment of new Priority 7 veterans. However, this bill could lead us in that direction.

I would also point out that VA already has authority to provide many veterans with non-VA care at VA expense due to "geographic inaccessibility" to VA care. In using that authority, VA takes into account the individual veterans needs and ability to get to VA care. This measure would significantly redefine "accessibility" and limit the ability of our field facilities to make these decisions.

Finally, as you know, we are now in the process of carrying out a major health care planning process known as CARES (Capital Assets Realignment for Enhanced Services). During that process, we believe that enactment of H.R. 2379 would be inappropriate and potentially disruptive.

The CARES initiative is the planning process for determining the capacity and placement of VA health care facilities, their accessibility, and the acute care infrastructure necessary to meet the current and future health care needs of veterans. At this time we are at a crucial stage of the process. In August, I submitted a draft National Plan to the CARES Commission, and the Commission is currently conducting a series of hearings to obtain input from the various stakeholders, including, veterans, veterans service organizations, Members of Congress, Senators, and local and State officials. Hearings will continue through October 21, and thereafter the Commission will prepare its own and report and recommendations and submit them to the Secretary for his consideration and final decision. The Commission's report and recommendations will be submitted in December, and the Secretary will make his final decision by the end of that month.

The CARES draft National Plan incorporates access criteria that were developed through the application of state-of-the-art methodology that was capable of great precision in measuring access, and detailed information to support planning decisions. The CARES approach involved determining the percentage of enrollees living within specific travel times to the nearest, appropriate VHA facility. The data obtained from the methodology allowed access within each market to be scored with regard to two "thresholds." The first threshold was a minimum *percentage* of enrollees living *within* a specified travel time to obtain VA primary care. The second threshold provided that notwithstanding the percentage of enrollees living within these travel times, the total *number* living *outside* the guidelines could not exceed a specified number. In other words, to qualify as an "access" planning initiative according to the criteria developed for CARES, a market had to first meet a *relative* standard (percentage living within access guidelines) as well as an *absolute* standard (a specified number of enrollees living outside access guidelines).

We believe that these exacting and precise access criteria have enabled VA to develop a cost effective investment strategy to improve access in selected markets and ensure the availability of the acute care infrastructure. We are concerned that enactment of H.R. 2379 could seriously disrupt the months of planning and analysis already invested in the CARES process. By forcing reconsiderations and revisions to the market plans of the 21 Veterans Integrated Service Networks (VISNs), it could result in an unacceptable delay in the Secretary's final decision.

Mr. Chairman, this concludes my prepared remarks. I would be pleased to answer questions about the two bills and our position on the bills.

STATEMENT OF
CATHLEEN WIBLEMO, DEPUTY DIRECTOR FOR HEALTH CARE
VETERANS AFFAIRS AND REHABILITATION DIVISION
THE AMERICAN LEGION
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
H.R. 2379, THE RURAL VETERANS ACCESS TO CARE ACT OF 2003
AND
H.R. 3094, THE VETERANS TIMELY ACCESS TO HEALTH CARE ACT OF 2003

SEPTEMBER 30, 2003

Mr. Chairman and members of the Subcommittee:

Thank you for this opportunity to present The American Legion's views on H.R. 2379, The Rural Veterans Access to Care Act of 2003 and H.R. 3094, The Veterans Timely Access to Health Care Act of 2003. We commend the Subcommittee for holding this hearing to discuss these two important pieces of Veterans' Health care legislation

H.R. 2379, the "Rural Veterans Access to Care Act of 2003"

This legislation would require each Veterans Integrated Services Network (VISN) within the Veterans Health Administration (VHA) to reserve five percent of its total annual appropriation to provide services at non-VA medical facilities for veterans who must travel more than 60 minutes to a VA facility. The American Legion has long advocated for and supports the goal of providing greater access to health care for veterans in rural or geographically remote areas where VA has no medical facilities. The American Legion; however, does not believe that forcing VISNs to divert badly needed resources to non-VA providers is the solution.

The Capital Asset Realignment For Enhanced Services (CARES) process currently underway is intended, in part, to address the very issue that is the subject of this legislation by identifying regions that are medically underserved for veterans (service gaps). CARES Access Driving Time Guidelines used to develop planning initiatives are identical for primary care in highly rural areas to the driving time proposed in this legislation: 60 minutes. The CARES Draft National Plan does not employ the "one-size-fits-all" approach of this bill, but rightly relies on a mix of realignment of existing VHA facilities, establishment of new ones and contracted services to reduce gaps in services to veterans in highly rural areas within each VISN.

The plan proposed in H.R. 2379 would complicate the Veterans Equitable Resource Allocation (VERA) system now in place by requiring every VISN to sequester 5 percent of its appropriation, regardless of whether highly rural or geographically remote areas exist.

The VA health care system started FY 2003 with five months of a continuing resolution that placed all VISN's in the predicament of conducting FY 2003 business with a FY 2002 budget; they started the current year in the red. To have only seven remaining months in a fiscal year to operate with a known budget is extremely difficult. To require a 5 percent reserve of an operating budget that is already insufficient compounds this chaotic situation and takes away some of the flexibility VISNs have in allocating resources within their region.

The American Legion is also concerned about reimbursement rates. This legislation does not specify reimbursement rates for services. Generally, payment rates for medical services purchased by the Federal government are predicated on the Medicare Part B guidelines of the Centers for Medicare & Medicaid Services (CMS). If enacted, what limits would be placed on charges made by contract providers? While a potential windfall for the contractors, it could prove too costly for an already seriously underfunded budget.

Additionally, there is no guarantee that doctors, hospitals or clinics in highly rural or geographically remote areas would be able to accept new VA patients, especially where a high percentage of the patient base is already dependent on Medicare Part B and Medicaid. Many rural and geographically remote areas are medically underserved due to health professional shortages. They also have a high percentage of the population living below the poverty level and many over age 65 and they also have high infant mortality rates. Because of the disproportionate numbers of the elderly and poor in rural areas, rural community clinics and hospitals often find themselves in financial trouble and are forced to choose between closure and a shift in core strategies away from acute inpatient care. Successful conversion to an organization that provides non-acute health care service is more apt to occur than closure when the population's demand for health care and ability to pay for it are high, competition from other hospitals is substantial, and hospitals have established strategies to provide alternative forms of health care, according to a study supported by the Agency for Health Care Policy and Research. Unfortunately, these success factors are rarely present in highly rural or geographically remote areas.

H.R. 3094, the "Veterans Timely Access to Health Care Act oF 2003"

This legislation addresses access to care by requiring VA to furnish health care services in a non-Department facility for veterans waiting beyond 30 days for primary care. While The American Legion conceptually agrees with the necessity to address the problems in access to VA health care, there should be reservations about this legislation as an unfunded mandate. Authorization is provided but there are no accompanying funds.

The legislation also offers a solution to the internal delays in service by authorizing treatment outside of the system. It does not address the root causes of the problem, which are inappropriate funding, an adequate and appropriate staff mix, and state of the art health care facilities that allow sufficient space and function for the optimal delivery of care.

Mr. Chairman, The American Legion adamantly believes that the long-term solution to these questions is to be found in mandatory funding for VHA. Funding for VA health care currently falls under discretionary spending within the Federal budget. VA health care budget competes

with other agencies and programs for federal dollars each year. The funding requirements of health care for service-disabled veterans are not guaranteed under discretionary spending.

VA's ability to treat veterans with service-connected injuries is dependent upon discretionary funding approval from Congress each year. Under mandatory spending, however, VA health care would be provided funding by law for all enrollees who meet the eligibility requirements, guaranteeing yearly appropriations for the earned health care entitlement of veterans.

I thank the Subcommittee for this opportunity to present The American Legion's views and look forward to working with you and the Subcommittee on these issues.

STATEMENT OF

DENNIS CULLINAN, DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

TO THE

SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

H.R. 2379, *RURAL VETERANS ACCESS TO CARE ACT*; AND
H.R. 3094, *VETERANS TIMELY ACCESS TO HEALTH CARE ACT*

WASHINGTON, D.C. SEPTEMBER 30, 2003

On behalf of the 2.6 million men and women of the Veterans of Foreign Wars of the United States and our Ladies Auxiliary, I would like to express our gratitude for allowing our organization to testify at today's important hearing.

The two bills under consideration today go to the heart of what we believe to be the Department of Veterans Affairs' (VA) gravest problem: veterans' lack of access to the health care system. As we have seen throughout the country, our nation's obligation to provide for its sick and disabled veterans does not automatically mean that veterans can access their health care system.

Despite record increases over the last several years, the VA budget is still far short of what is needed to adequately care for this nation's veteran population and, as a result, VA has limited veterans' access to health care. As the *President's Task Force to Improve Health Care Delivery for our Nation's Veterans* observed, "many of those who have made the commitment to defend our country have not always received fair, equitable, or appropriate access to health care once their military service has been completed. The Federal Government has been more ambitious in authorizing veteran access to health care than it has been in providing the funding necessary to match declared intentions."

The first bill under consideration today aims to improve access for veterans living in rural, isolated locations. H.R. 2379, the *Rural Veterans Access to Care Act*, sets aside five percent of the VA Medical Care Appropriation to provide contract health care services at local medical care facilities for those veterans who live 60 minutes or more from a VA facility.

While the VFW believes that access for rural veterans does need to be improved, we believe that this legislation is the incorrect solution to the problem. This legislation unfairly takes benefits that are for all veterans and specifically earmarks them for one targeted group. This legislation ties up a concrete portion of the Medical Care Appropriation solely for a distinct class of veterans. All veterans are equally eligible for VA health care; allocating funds in this manner is not a fair solution.

We believe that, like all VA health care access problems, this is an issue of funding. If VA had proper funding, it would be able to construct and fully staff more access points such as Community Based Outpatient Clinics to provide equitable access to all veterans throughout the country. While there are always going to be certain veterans whose remote location would make access difficult, shifting funds is not the answer, providing more is.

We would also comment that VA, under certain circumstances, already has the authority to contract for health care. For those veterans who live in extremely remote locations or for those veterans who do not have a specialized service available in their area, VA is authorized to contract for care at non-VA facilities. We would encourage that this practice be expanded to care for additional veterans who are at a hardship because of their remote location. Again, appropriate funding would need to be provided to cover the costs.

The other legislation under consideration takes a different approach at improving access. It aims to reduce the amount of time veterans must wait for health care

appointments. H.R. 3094, the *Veterans Timely Access to Health Care Act*, codifies VA's stated goal of seeing a veteran within 30 days of an appointment request.

Under this legislation, Category 1-7 veterans living in a Veterans Integrated Service Network that is not able to see 90% of its patients within the 30-day standard are eligible to receive care with their private physicians at non-VA facilities. For Category 8 veterans, non-VA care would be at the Secretary's discretion. In both cases, the veterans would pay nothing and VA would reimburse the facilities at the Medicare rate.

We support this legislation and believe that this legislation is a step in the right direction towards improving access to health care. It is completely unacceptable that there are still nearly 100,000 veterans who have been waiting six months or more for primary health care appointments and that there are still some places where the wait is nearly two years for specialty care. It is unconscionable that our nation treats the health of our sick and disabled veterans so poorly.

If this legislation is enacted and combined with proper funding and staffing levels, those veterans who have been waiting months would be able to receive the health care they earned through their service in defense of this country. It would dramatically level the playing field when it comes to health care access. Veterans, just as you or I can, would receive health care as they need it, not when it is convenient for VA.

Additionally, we believe it would serve as an added impetus for VA to improve its own practices, to incorporate workable private sector methodologies and for Congress to better fund the VA health care system. Together, improvements in these areas would render this legislation obsolete. Our veterans deserve no less.

Mr. Chairman, this concludes our testimony. I would be happy to answer any questions that you or the members of this subcommittee may have.

STATEMENT OF

CARL BLAKE,

ASSOCIATE LEGISLATIVE DIRECTOR,

PARALYZED VETERANS OF AMERICA

BEFORE THE HOUSE COMMITTEE ON VETERANS' AFFAIRS,

SUBCOMMITTEE ON HEALTH

CONCERNING

H.R. 2379, THE "RURAL VETERANS ACCESS TO CARE ACT OF 2003"

AND H.R. 3094, THE "VETERANS TIMELY ACCESS TO HEALTH CARE ACT"

SEPTEMBER 30, 2003

Chairman Simmons, Ranking Member Rodriguez, members of the Subcommittee, PVA would like to thank you for the opportunity to testify today concerning H.R. 2379, the "Rural Veterans Access to Care Act" and H.R. 3094, the "Veterans Timely Access to Health Care Act." Timely access to care is certainly something that the Department of Veterans Affairs (VA) health system is struggling with.

H.R. 2379, the "Rural Veterans Access to Care Act of 2003"

Although PVA recognizes the difficulties some veterans have in accessing health care within the VA, PVA believes that it is a viable system. With over 800 community-based outpatient clinics, the VA has established a good network for meeting the needs of a vastly spread veterans population.

PVA is opposed to H.R. 2379 that would allow the VA to contract health care services to local private facilities for veterans living in rural areas. PVA believes that contracting services to private facilities will set a dangerous precedent, encouraging those who would like to see the VA privatized. Privatization is ultimately a means for the federal government to

shift its responsibility of caring for the men and women who served.

PVA is also troubled by the provision of this legislation that would require the VA to set aside no less than five percent of its health care appropriations dollars each year to be allocated to each network proportionally so that the networks can contract out health care services if necessary. Considering that VA health care is already severely underfunded, this requirement would only place a greater strain on a system that is struggling to meet the ever increasing demands of our veterans. Adequate funding must be the priority in allowing the VA to maintain its core programs which include service for spinal cord injured veterans, blinded veterans, veterans who suffer from mental illness and veterans who have other specialized needs. If a percentage of health care dollars is taken from the initial allocation, even the most severely disabled veterans will be at risk of less than quality care.

H.R. 3094, the "Veterans Timely Access to Health Care Act"

H.R. 3094 would establish standards of access to care within the VA health system. Under the provisions of this legislation, the VA will be required to provide a primary care appointment to veterans seeking health care within 30 days of a request for an appointment. If a VA facility is unable to meet the 30-day standard for a veteran, then the VA must make an appointment for that veteran with a non-VA provider, thereby contracting out the health care service. The legislation also requires the Secretary of the VA to report to Congress each quarter of a fiscal year on the efforts of the VA health system to meet this 30-day access standard.

Access is indeed a critical concern of PVA. The number of veterans seeking health care from the VA in recent years has risen dramatically. Since 1995, the number of veterans enrolled in the VA has risen from approximately 2.9 million to more than 5 million. Despite the Secretary's decision to close enrollment of Category 8 veterans earlier this year, the numbers of enrolled veterans only continues to increase as we begin adding new veterans from the war in Iraq and Afghanistan.

Unfortunately, VA health-care resources do not meet the increased demand for services and the system is unable to absorb this significant increase. With tens of thousands of veterans on a waiting list, waiting at least six months or more for care, VA has now reached capacity at many health-care facilities and closed enrollment to new patients at many hospitals and clinics. Additionally, VA has placed a moratorium on all marketing and outreach activities to veterans and determined there is a need to give the most severely service-connected disabled veterans a priority for care.

To ensure that all service-connected disabled veterans, and all other enrolled veterans, are able to access the system in a timely manner, it is imperative that our government provide an adequate health-care budget to enable VA to serve the needs of veterans nationwide. Access standards without sufficient funding are standards in name only. PVA is concerned that contracting health care services to private facilities when access standards are not met is not an appropriate enforcement mechanism for ensuring access to care. As we stated with regard to H.R. 2379, paying for contract care out of an already inadequate VA health care appropriation draws even more resources away from the funds needed to pay for VA's core services. Likewise, contracting out to private providers will leave the VA with the difficult task of ensuring that veterans seeking treatment at non-VA facilities are receiving quality health care. We do think that access standards are important, but we believe that the answer to providing timely care is in providing sufficient funding in the first place in order to negate the impetus driving health care rationing. For these reasons, PVA cannot support H.R. 3094.

PVA appreciates the efforts of this Committee to ensure that veterans receive timely access to care. However, we must emphasize that the VA will continue to struggle to provide timely access without adequate funding provided by this Congress. We look forward to working with this Committee to ensure that veterans not only receive timely access to care, but high quality care as well.

PVA would like to thank you for the opportunity to testify today. I would be happy to answer any questions that you might have.

STATEMENT OF
ADRIAN ATIZADO
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
UNITED STATES HOUSE OF REPRESENTATIVES
SEPTEMBER 30, 2003

Mr. Chairman and Members of the Subcommittee:

On behalf of over 1.2 million members of the Disabled American Veterans (DAV) and its Women's Auxiliary, we are grateful for the opportunity to provide our views on two pieces of legislation affecting our members.

One of the Department of Veterans Affairs' (VA's) primary missions is the provision of health care to our nation's sick and disabled veterans. The Veterans Health Administration (VHA) is the nation's largest direct provider of health care services. Starting less than a decade ago, VA's delivery of health care to veterans began to change from an inpatient-oriented approach to an outpatient model with more than 1,300 access sites in veterans' communities across the United States. To continue improving access for eligible veterans to VA's high quality medical care, we are considering two bills on today's agenda, H.R. 2379, the Rural Veterans Access to Care Act of 2003, and H.R. 3094, the Veterans Timely Access to Health Care Act.

H.R. 2379

The purpose of H.R. 2379 is to improve access to VA health care for highly rural or geographically remote veterans. This legislation would require VA to prescribe regulations to define highly rural or geographically remote veterans, and to include in the definition veterans with driving times of 60 minutes or greater to reach a VA health care facility. This bill would also require VA to ensure funds of not less than 5 percent of its Medical Care account be made available to improve access to care for veterans in highly rural or geographically remote areas through contract for care and other authorities. In addition, unused funds from any service region may be reallocated where needed solely for the treatment of highly rural or geographically remote veterans. After the end of the third fiscal year, the VA would be required to review the operation and to make adjustments to the percentage in effect nationally or by geographic region through recommendation to Congress.

H.R. 3094

The goal of H.R. 3094 is to provide timely access to VA health care. To accomplish this, VA is required to prescribe and periodically review for an annual report to the Committees on Veterans' Affairs of the Senate and House of Representatives standards of time to access medical

care. The time to access medical care is to be determined from the date a veteran contacts VA for an appointment to the date the visit to the provider is completed. Further, this bill prescribes 30 days as the standard for access to a primary care provider. VA would also be required to determine over the first quarter of the first calendar year after enactment of this measure a compliance rate for each Veterans Integrated Service Network.

This bill authorizes VA to furnish health care and services in a non-Department facility to any eligible veteran for which VA is unable to meet the standards for access to care in a VISN with a compliance rate less than 90 percent. With respect to Priority Group 8 veterans, VA may furnish health care and services in a non-Department facility under its discretion. Payment for such care may not exceed the reimbursement rate paid under Part B of the Medicare program, and the non-Department facility may not bill the veteran for any difference between the facility's charges and the amount paid by VA. In addition, VA would be required to submit to the House and Senate Committees on Veterans' Affairs a comprehensive report for each calendar year with respect to waiting times.

DAV agrees that veterans must have access to timely health care and that VA must be held accountable for meeting its own access standards. We have often stated that through their extraordinary sacrifices and contributions, veterans have *earned* the right to free health care as a continuing cost of national defense. We adamantly believe America's citizens, as beneficiaries of veterans' service and sacrifice, want the government to fully honor its moral obligation to provide quality and timely health care services to wartime service-connected disabled veterans.

In so far as H.R. 2379 considers timely access for veterans based on their geographic location in relation to a VA health care facility, careful consideration must be given to its impact on the CARES process. This nationwide initiative is designed to align VA's capital assets to ensure that veterans' future needs for accessible, quality health care are met. Like H.R. 2379, the CARES initiative seeks to address access to care through standards of access, such as specific travel times of urban, rural, and highly rural veterans to the nearest VHA facility.

The wait list for veterans seeking medical care and VA's decision to stop enrollment for new Priority Group 8 veterans this year confirms that the level of resources is not sufficient to continue open enrollment. DAV is concerned about the setting aside of funds from VA's Medical Care account to provide highly rural or geographically remote veterans improved access to VA health care because it could have a negative impact on access to care by other veterans and exacerbate this tenuous situation.

With regards to H.R. 3094, the language pertaining to the amount VA would pay for outpatient services provided by a non-Department facility or provider is not clear. Specifically, if VA's reimbursement rate under Part B of the Medicare program refers to the full fee schedule or 80 percent of the fee schedule amount for which Medicare pays for physicians' services after the beneficiaries have met the annual Part B deductible. It is important to note that participating physicians can only receive equitable compensation of services rendered by billing Medicare beneficiaries the remaining 20 percent of the fee schedule, plus any deductible, commonly referred to as coinsurance.

Certainly, we agree no veteran should be billed for any health care services furnished by VA. Under this measure, however, if a non-Department facility or provider will receive the 80 percent of the fee schedule amount for which Medicare pays for a particular service, and they are not allowed to bill the veteran for any difference between the facility's billed charges and the amount paid by VA, then, we believe this may act as a disincentive for non-Department facilities to accept and treat veterans.

Furthermore, we are deeply concerned that the initiative in both bills to contract care in order to meet access standards would shift medical services and veteran patients from VA to the private sector. The proposal to contract care to non-Department facilities and providers would encourage VA to refer patients, and the dollars used to subsidize their care outside a system specifically created for veterans and their health care needs. This proposal sets a dangerous precedent that, if allowed to expand, could endanger VA facilities' ability to maintain their full range of specialized inpatient services for all veterans. It would erode VHA's patient resource base, undermining VHA's ability to maintain its specialized service programs, and endanger the well being of veteran patients.

To provide timely access to care, we must identify and immediately correct the underlying problems and not the symptoms. We do not oppose other initiatives assisting veterans who reside in underserved areas. We are, however, opposed to any initiative that would turn VA into an insurer rather than a provider of health care. We feel VA must use its resources to maintain the base of its health care services, which are provided through and by VA health care facilities and health care providers. This traditional form of VA health care has served well to the benefit of all veterans to offer an uninterrupted flow of services to veterans in need, and ensure the quality of those services no matter where or when they are provided.

Due to insufficient funding, VA is struggling to provide timely health care to all veterans seeking care. We believe that VA must have guaranteed full funding for all priority groups to meet the requirements of any standard for access to care. This Subcommittee is well aware of the funding crisis VA health care is facing and its impact on sick and disabled veterans who depend on VA's specialized programs and services. In the years since open enrollment, VA has been forced to do more with less. Even though over the past two budget cycles, Congress has increased discretionary appropriations for veterans' health care, the funding levels have simply not kept pace with inflation and the significant increase in demand for services.

If given proper funding, VA should be held accountable for meeting demand in a timely manner and only as a last resort would we want care to be contracted out. Moreover, if VA receives sufficient appropriation, it should be able to plan for the appropriate number of staff necessary to provide veterans care within VA facilities in a cost-effective manner.

In closing, DAV thanks this Subcommittee for holding this hearing and for its interest in improving benefits and services for our Nation's disabled veterans. The DAV deeply values the advocacy this Subcommittee has always demonstrated on behalf of America's service-connected disabled veterans and their families. We sincerely appreciate the opportunity to present our views on these important measures.

Vietnam Veterans of America

8605 Cameron Street, Suite 400 • Silver Spring, MD 20910 • Telephone (301) 585-4000
Main Fax (301) 585-0519 • Advocacy (301) 585-3180 • Communications (301) 585-5245 • Finance (301) 585-5542
World Wide Web: http://www.vva.org

A Not-For-Profit Veterans Service Organization Chartered by the United States Congress

Testimony of

Vietnam Veterans of America

Presented by

Rick Weidman
Director of Government Relations

Before the

House Veterans' Affairs Committee
Subcommittee on Health

Regarding

Veterans Timely Access to Health Care Act
H.R. 3094
and
Rural Veterans Access to Care Act of 2003
H.R. 2379

September 29, 2003

Vietnam Veterans of America

House Committee on Veterans Affairs
Subcommittee on Health
H.R. 3094 and H.R. 2379
September 30, 2003

On behalf of Vietnam Veterans of America (VVA), I want to thank the Chairman and other distinguished members of this Subcommittee for affording us the opportunity to testify before you here today on an issue that has emerged as one of critical importance to veterans who use the VA for their health care. We applaud you for acknowledging the seriousness of the current situation and holding this hearing.

Now, to the issues at hand:

Among the conclusions of the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans was this: "The Federal Government has been more ambitious in authorizing veteran access to health care than it has been in providing the funding necessary to match declared intentions." In its final report, the Task Force noted that, as of January 2003, "at least 236,000 veterans were on a waiting list of six months or more for a first appointment or an initial follow-up." To ameliorate this unacceptable situation, Secretary Principi invoked the enrollment authority granted him under the Veterans Health Care Eligibility Reform Act of 1996 (Public Law 104-262), prohibiting any additional enrollment of the newly created Priority Group 8 veterans.

So, has this significantly reduced the waiting list? According to reports, there are still in excess of 100,000 veterans who have to wait more than six months – in some cases, up to a year or more – to see a primary care physician or a specialist. The system is breaking. VVA believes that passage of H.R. 3094, the Veterans Timely Access to Health Care Act, and H.R. 2379, the Rural Veterans Access to Care Act of 2003 can only help force a change for the better by holding the system more accountable for its failures.

H.R. 3094 would mandate that an initial appointment with a primary care provider be no more than 30 days from the date on which a veteran contacts the VA seeking an appointment. This is entirely reasonable.

To ensure accountability, the act as currently written would require that the Secretary of Veterans Affairs submit to both the House and Senate Committees on Veterans' Affairs a comprehensive report on the experience of the Department for each calendar-year quarter. A report would be due not later than 60 days after the end of each quarter. What H.R. 3094 does not spell out is what sanctions the Committees might invoke if the VA either flouts the law or neglects to comply with its provisions. Nor does the Act require VA to hold senior managers accountable for ensuring best possible compliance.

At the same time, we fear that H.R. 3094, while attempting to "fix" one part of the system, might rupture other parts. The law of unintended consequences seems to be only immutable law on Capitol Hill. Unless there is an infusion of funding – and, as you know, Mr. Chairman, it remains questionable as to whether or not the system will get the infusion of $1.8 billion that it desperately needs to meet the demands on its medical services – enactment of this act will ring hollow. VVA does not want, as a byproduct of

this legislation, the system to further bar from enrollment of ever greater numbers of deserving veterans.

VVA believes that unless and until the VA's medical operations are appropriately funded, the system will suffer one problem after another. What we don't want is a situation akin to the tale of the little Dutch boy who put his finger in the dyke to plug up one hole only to have another hole spring a leak.

What really is needed in this time of war is for the Congress, with or without the active support of the President, to ensure the proper funding of veterans' health care. If funding had not been flat-lined for three successive fiscal years during the mid-1990s, we would not have to continually be playing inadequate catch-up each year. Rather than debating the need for $1.8 billion for the new fiscal year, we would be discussing funding $8-$10 billion a year more, as you can see in the accompanying graph. In developing this graph, VVA must point out, we took very conservative medical inflation figures from the Centers for Medicare and Medicaid Services.

By your leave, Mr. Chairman, VVA has included copies of our "White Paper" issued in late July of 2003 that details how the veterans healthcare funding in America is now suffering a structural shortfall that only gets greater each year. We also request that this White Paper be issued into the record along with our testimony today. The base funding must be restored by going "off-budget" in a four year plan of $3.5 Billion per year in addition to the on-budget percentage increases comparable to that which the President has requested last year and this year. The problem with those percentage increases is that the base is just too darn low.

All of the hubbub about not losing the $1.8 billion from the VA-HUD bill, all the press releases and statements by all of the major veterans' service organizations on this issue, ties in to the purpose of this hearing today. First and foremost, we need to properly and appropriately fund the VA's medical operations *taking into account both medical inflation and per capita usage of the system.* I think that then, if a veteran has to wait more than 30 days to see a physician it will be a true example of mismanagement or worse, not a situation of an overburdened system juggling inadequate resources.

Each of these bills address important questions relating to increased accountability of the veterans health care system. Both gross underfunding AND lack of proper accountability has led us into this mess. Much greater funding accompanied by stringent accountability measures is the only way to restore our veterans health care system to a fully functioning system that properly meets the needs of every generation of American veterans

Again, VVA is grateful for having had the opportunity to present our views before you today.

WHITE PAPER

The Position of Vietnam Veterans of America On Health Care Funding For *All* Veterans

July 2003

Vietnam Veterans of America

8605 Cameron Street, Suite 400 • Silver Spring, MD 20910 • Telephone (301) 585-4000
Main Fax (301) 585-0519 • Advocacy (301) 585-3180 • Communications (301) 585-5245 • Finance (301) 585-5542
World Wide Web: http://www.vva.org

A Not-For-Profit Veterans Service Organization Chartered by the United States Congress

July 2003

Dear Friends and Colleagues,

This White Paper makes the argument for what Vietnam Veterans of America (VVA) and other Veterans Service Organizations (VSOs) have been advocating for too long: the need to shift the funding of the VA's medical operations from a discretionary to an obligatory model at an appropriate level of funding. We believe the time for Congress and the President to address and rectify this situation is now, while another generation of American troops is fighting a new, global war that doesn't promise a swift conclusion.

It is our hope that all the VSOs and all Americans will unite and push for enactment of legislation to restore the base funding for VA medical operations; and to bring a measure of sanity to how veterans health-care is funded so that we can turn our attention to how to improve that care and introduce greater accountability and efficiencies into the system.

We look forward to working with our fellow veterans and with members of Congress who believe that this is the right thing to do and the right time to do it.

We welcome your comments and your support.

Sincerely,

Thomas H. Corey
National President

Vietnam Veterans of America

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EXECUTIVE SUMMARY

The highest legislative priority of Vietnam Veterans of America is the institution of obligatory, or assured, funding for medical operations at the VA based on the per capita use of the veterans health-care system (including long-term care) at the 1996 level of funding, indexed for medical inflation.

The debate of the past several years has been whether to fund the veterans health-care system at a very inadequate level or a grossly inadequate level. This debate needs to end. We must give more than lip service to the health-care mandates set forth in law, and by the will of the American people, to care for those who have borne the battle.

In the mid-1990s, the VA health-care system welcomed higher income, non-disabled veterans, with the caveat that these enrollees pay a nominal co-payment. The rationale behind this initiative was to ensure a patient base that would support the infrastructure needed to develop a modern, integrated health-care system. Congress endorsed this initiative and enacted Public Law 104-262, the Veterans Health Care Eligibility Reform Act of 1996.

Because the law did not mandate a level of funding, it established an annual enrollment process and categorized veterans into "priority groups" to manage enrollment. Last year, the system hemorrhaged, and Secretary Principi had to make a difficult call. Overburdened by an influx of enrollees, the VA did not have the financial resources to provide care for all who chose to enroll. The Secretary then temporarily suspended new enrollments of Priority 8 veterans. This suspension, which went into effect January 17, 2003, will continue through Fiscal Year 2004. Although this decision is to be reviewed annually, many fear that Priority 8 veterans have been effectively banished from the health-care system as the VA, with no promise of an infusion of supplemental appropriations, refocuses on its "core mission" of serving veterans "with service-connected disabilities, the indigent, and those with special health care needs."

The VA is not assured adequate funding that complies with Public Law 104-262. This law, undermined by years of flat-line budgeting by Congress and by medical inflation, effectively strained the VA system beyond capacity and rendered the VA unable to respond adequately to the needs of veterans who have chosen to use its health-care system. Access to this care is their right as veterans, and that right is being abrogated.

To adequately serve all of those who seek its services, the VA needs $28.5 billion in hard, appropriated dollars in FY 04. Using a very conservative methodology and government figures, some $36 billion should have been appropriated for VA medical operations in FY 04. To restore the eroded funding base would take a four-year "off-budget" restoration plan of $8-10 billion. To avoid future funding crises, Congress must go beyond the rhetoric of considering whether the current discretionary-funding model needs to be replaced by an obligatory system of funding indexed both to per capita costs of treatment and medical inflation. Congress and the President must not pass the buck any longer. They must grapple with the issues keeping the compact between our government and our veterans at the forefront of debate, and they must enact legislation that will ensure a consistent, predictable, and appropriate level of funding for VA medical services.

The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional as to how they perceive the Veterans of earlier wars were treated and appreciated by their nation.

– George Washington

INTRODUCTION

Americans have long held that health care for veterans is a national obligation, part of the covenant between the American people, through our democratically elected representatives and agencies of government, and the men and women who have pledged to defend the Constitution and the cherished principles of our nation. Because those who render military service pledge not only their loyalty but their life, knowing that they may be called to combat, understanding that they may give up their life, this covenant is more profound than a legal contract. Now, at a time when a new generation of our sons and daughters is on the front lines defending America's interests, it is our obligation as citizens of a generous and compassionate society to ensure that the funding to care for the injuries, illnesses, and disabilities they may suffer is assured and not relegated to a "discretionary" appropriation of inadequate proportions.

Those who serve during times of war or conflict, particularly those who are deployed to a war zone, return home changed. Many are seared psychologically. Some are wounded or maimed by the weapons of modern warfare. Yet just as they have fulfilled their obligation to their country – to all of us – it is our collective obligation to do all that we can, through the appropriate agencies of government, to restore as much as possible each veteran who has been lessened physically, psychologically, or economically; and all that we can individually and through our communal and religious institutions to heal each veteran who has been lessened spiritually.

All Americans committed to justice for veterans understand that the annual budget battles in Congress do little to inspire confidence that we will do right by our veterans. Budgets and appropriations are, of course, a reflection of the values and priorities of the administrators who design them and the legislators who approve them. What does "discretionary" funding for the care of men and women who defend our country say about America? Which is more important: the pet highway construction projects of a powerful member of Congress or adequate funding for veterans health care? What does the "temporary"

triage of veterans classified as "Priority 8" say about the state of the VA health-care system? Beyond political platitudes, what legislation will the administration and the congressional leadership debate and enact to eliminate the uncertainty in funding veterans health care?

The debate over the past several years has been whether to fund VA medical operations at a very inadequate level or a grossly inadequate level. The flat-lined budgets passed by Congress and signed by the President during the mid- and late-1990s so eroded the base funding for health care that the VA is hard-pressed to meet the mandate of its mission. This annual debate needs closure. It is time to act to ensure a consistent, predictable, and appropriate level of funding that will give more than lip service to the mandates for health care set forth in law, and by the will of the American people, for those who have borne the battle in the fertile fields of Europe, the islands of the South Pacific, the rice paddies and jungles of Southeast Asia, the sands of Kuwait and Afghanistan and Iraq, and the myriad peacetime confrontations of the Cold War.

BACKGROUND

The Department of Veterans Affairs, the second largest of the 15 Cabinet departments, is the largest integrated health-care provider in the nation, with 163 medical centers, more than 900 outpatient clinics, 180 nursing homes and domiciliaries, and 206 Vet Centers divided into 21 Veterans Integrated Service Networks administered under the aegis of the Veterans Health Administration.

In the mid-1990s, the leadership of the VA, with the bi-partisan support of Congress, embarked on a significant shift in policy. They opened the VA health-care system to non-indigent, non-disabled veterans, with the caveat that these enrollees pay a nominal co-payment. The rationale behind this initiative was to ensure a patient base that would support the infrastructure needed to develop a modern, integrated health-care system. Congress and the President endorsed this initiative, enacting Public Law 104-262, the Veterans Health Care Eligibility Reform Act of 1996, which gave the VA the legal authority to do what it had proposed.

The new law reaffirmed the VA's mandate to provide care for its core constituency: service-connected disabled veterans, indigent veterans, and others such as ex-prisoners of war and veterans who had been exposed to environmental hazards, toxic substances, and radiation. It also required that the VA provide "for the specialized treatment and rehabilitative needs of disabled veterans (including veterans with spinal cord dysfunction, blindness, amputations, and mental illness)."

However, even though the new law was predicated on the assumption that the VA would be reimbursed from Medicare as well as from third-party collections from private insurers for the services it provided, a provision of the law stipulated that "hospital care and medical services shall be effective in any fiscal year only to the extent and in the amount provided in advance in appropriations acts for such purposes." The law gave the Secretary of Veterans Affairs the authority and responsibility to determine eligibility for enrollment based on available resources in any given fiscal year. Although the law did not mandate a level of funding, or a standard of care, it did establish an annual enrollment process and categorized veterans into "priority groups" to manage enrollment (see Appendix for an explanation of these priority groups).

A confluence of events and conditions served to swell the roster of those who sought service at the VA. Outreach to veterans who had never considered care in VA facilities was stimulated by the fissures and faults of a national health-care system that does a terrible job of containing costs. Double-digit inflation priced health insurance beyond the reach of millions of Americans. The soaring costs of prescription drugs – and the unavailability of a drug program in Medicare – caused veterans to flock to the VA. The

Veterans' Millennium Health Care and Benefits Act of 1999 further increased demand by expanding benefits. Because funding of VA medical operations is not based on per capita usage, the VA's resources shrunk while enrollment was soaring. Caseloads ballooned. Waits for appointments to see physicians lengthened from several weeks to several months. Veterans using the system were frustrated by a system that had bogged down.

Last year, VA Secretary Principi had to make a difficult call. The system did not have the financial resources to provide care for all who chose to enroll. Confronted by dire fiscal realities, the Secretary created a new category, Priority 8, for prioritizing medical care in the VA system. ("Priority 8" is comprised of veterans who agree to pay specified co-payments and whose income and/or net worth is above the VA means-test threshold and the HUD geographic index.)

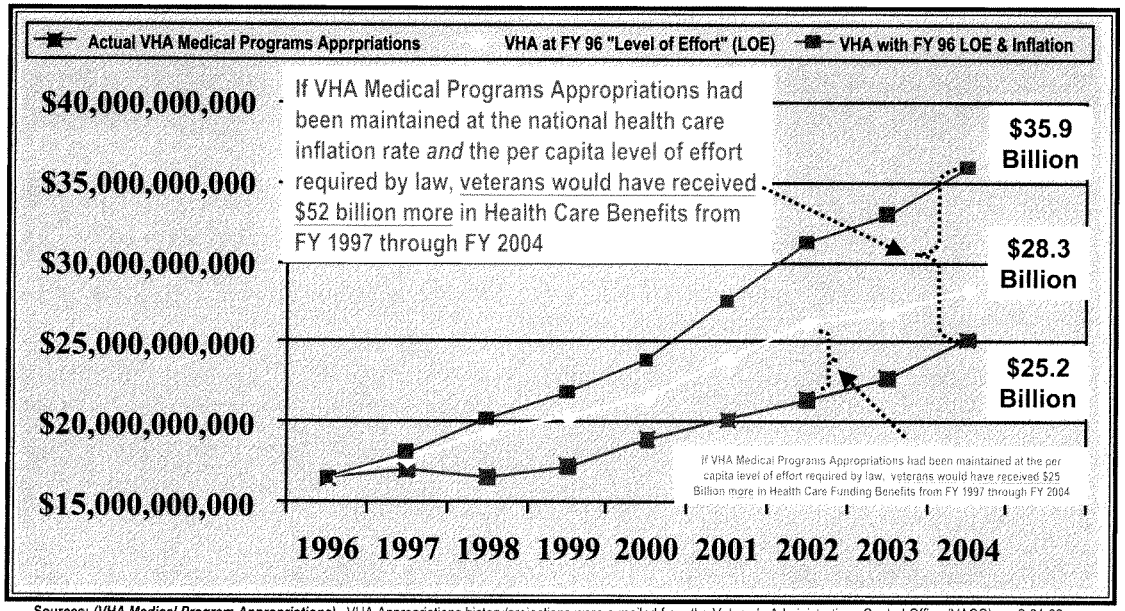
The Secretary then temporarily suspended new enrollments of veterans in that category. This suspension, which went into effect January 17, 2003, will continue through Fiscal Year 2004 (which runs from October 1, 2003, through September 30, 2004). While this decision is to be reviewed on an annual basis, many fear that Priority 8 veterans have been effectively banished from the health-care system as the VA, with no promise of an infusion in supplemental appropriations, refocuses on its "core mission" of serving veterans "with service-connected disabilities, the indigent, and those with special health care needs."

How did it come to pass that Secretary Principi felt compelled to take so drastic an action as suspending registration and access for Priority 8 veterans? Part of the answer lies in how the system is funded. The VA is not assured adequate funding that enables it to comply with the provisions of Public Law 104-262, which mandates that funding for health care meet the "level of care" provided by the VA in 1996. While recent increases to the VA health-care budget have been reasonable, the law has been effectively undermined by years of flat-line budgeting during the mid- to late-1990s. The situation has been compounded by the eroding effects of medical inflation, straining the VA system beyond capacity and rendering the VA unable to respond adequately to the needs of veterans who have chosen to avail themselves of its health-care system. This is their right as veterans, and that right is being abrogated.

The following graphs illustrate the problem. While enrollment in the VA system has increased by almost 120 percent since 1996 – from some 3.4 million to more than 7.0 million projected in FY 2004 – Veterans Health Administration (VHA) per capita expenditures have decreased over the same period by 30 percent (Graph 2, page 6). The ratio of patients to licensed practical nurses has shot up more than 100 percent, while the ratio of patients to registered nurses had grown by 67 percent (Graph 3, page 7). Likewise, the doctor-patient ratio has increased by almost 60 percent (Graph 4, page 8). While this situation is exacerbated by an increase in Priority 7 and 8 veterans, in fact more Priority 1–6 veterans entered the system over the same period (Graph 5, page 9).

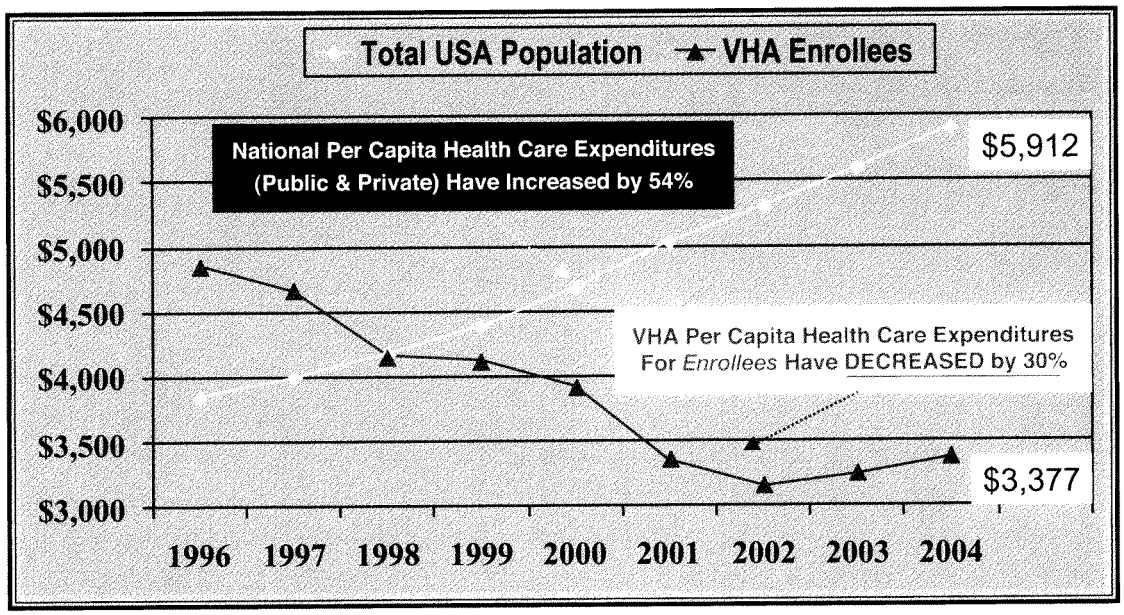
Perhaps most telling is Graph 1 (page 5): Had the level of funding mandated by law been met – and the law requires that funding for the VA's medical operations match the "level of effort" in Fiscal Year 1996 – this funding would be hovering at $36 billion for FY 04. The debate would reflect this higher figure. In order for the VA to serve all veterans who are eligible and who seek care at VA facilities, VA officials have acknowledged that, beyond the $1.7 billion they anticipate collecting in third-party billings in FY 2004, they will need at least $28.5 billion in hard, appropriated dollars to re-open the medical system to all eligible veterans in FY 04.

VHA Medical Programs "Should Spend" Budget



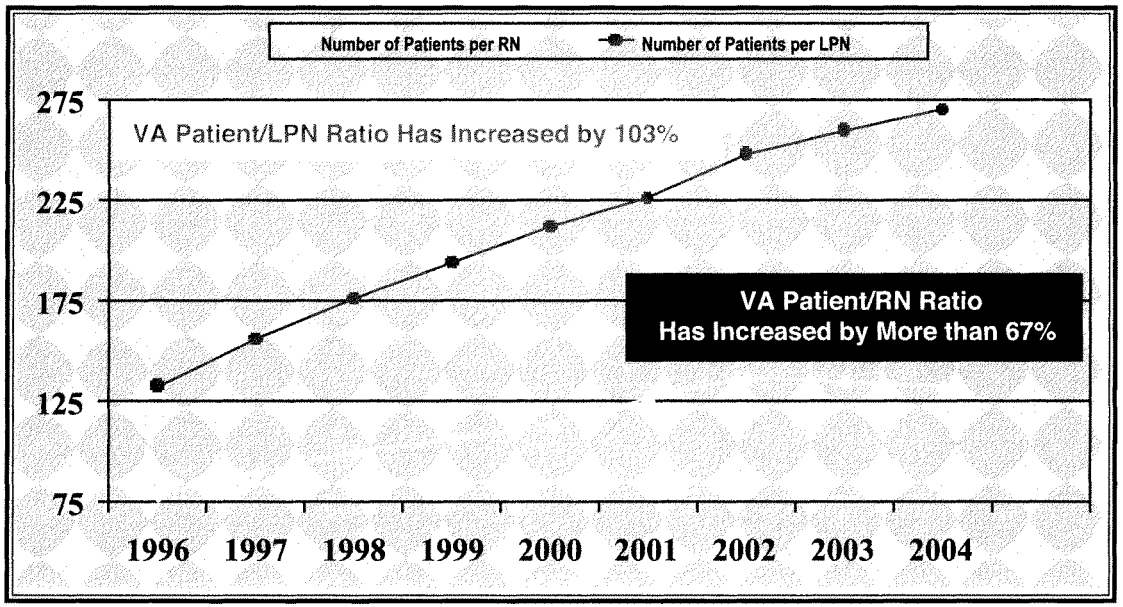
Sources: ***(VHA Medical Program Appropriations)*** - VHA Appropriations history/projections were e-mailed from the Veteran's Administrations Central Office (VACO) on 2-04-03.
(VHA at FY 96 "Level of Effort" Budget Line) - Data derived by multiplying the FY 96 Per Capita "Level of Effort" ($5,633) by the number of VHA Users. FY 96-98 VHA Users are a VVA estimate. FY 99-04 VHA Users came from the VHA Policy and Forecasting Office and utilize the "full demand" figures for FY 03 and 04.
(VHA at FY 96 LOE & Inflation Budget Line) – Health care inflation figures for each FY were faxed to VVA from the Centers for Medicare and Medicaid Services (CMS) Actuarial Offices, and can be viewed for 1998-2004 at www.cms.gov/statistics/nhe/projections-2002/t1.asp. The CMS data are conservative because they do not reflect price inelasticity accounted for in the slightly higher health care inflation figures of the Consumer Price Index (patients cannot as easily substitute lower cost drugs/treatments as in other sectors).

Annual Per Capita Health Care Expenditures



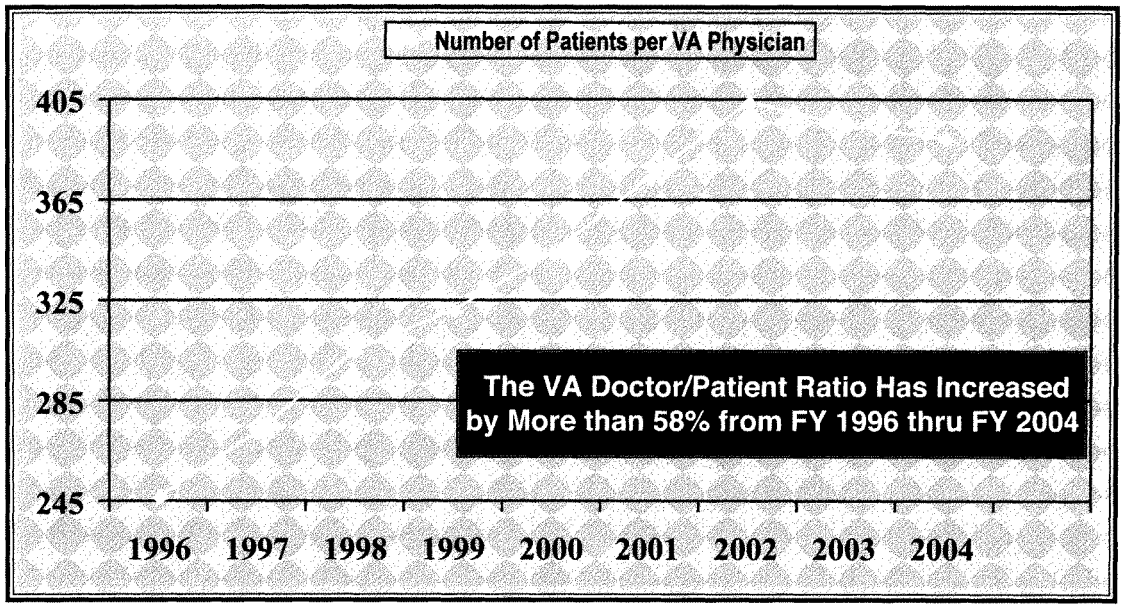
Sources: ***(National Health Care)*** - Per Capita Expenditures are derived from the Centers for Medicare and Medicaid Services data found at http://wwwcms.gov/statistics/nhe/, the "nhegdp01.zip" file (2nd table at bottom of web page). Projections for FY 02-04 are based on the average 5.5% per capita growth rate from FY 96-01.
(VHA) - Enrollee Per Capita Expenditures are derived by dividing FY 96-04 VHA Appropriations by the number of VHA enrollees. FY 96-98 are estimates based on the 16% enrollee/user difference in FY 99. FY 99-04 actual and projected enrollees are from the VHA Policy and Forecasting Office and utilize the"full demand" figures for FY 03 and 04. VHA Appropriations history and projections were e-mailed to VVA from the Veterans Administration Central Office (VACO) on 2-04-03.

VA Nurse/Patient Ratio



Source: Department of Veterans Affairs Forecasting and Policy Office Fax on 3-13-03.

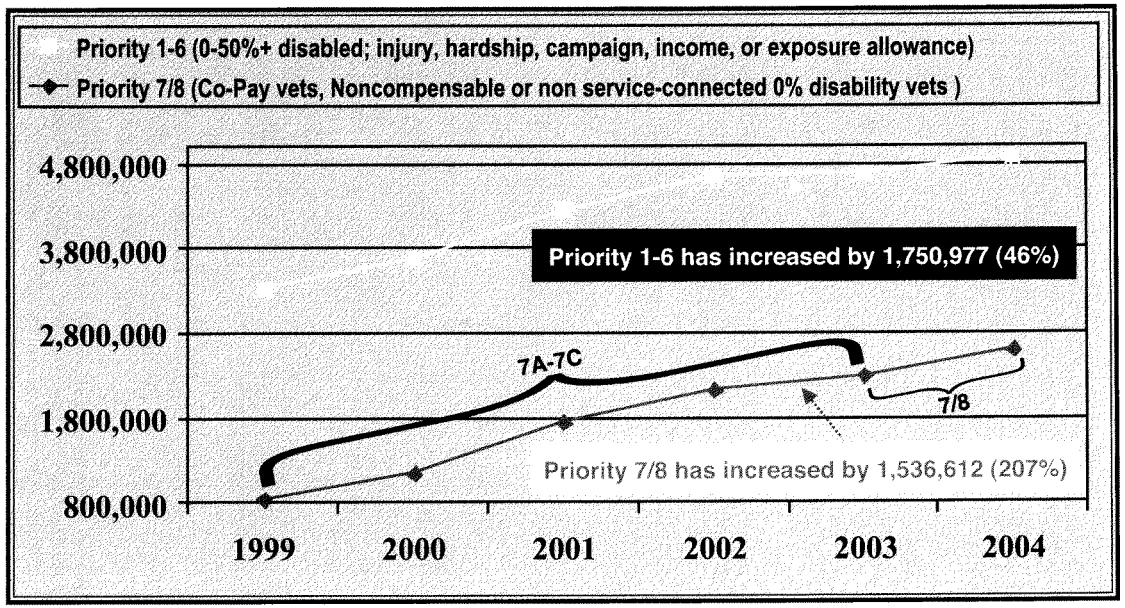
VA Doctor/Patient Ratio



Source: Department of Veterans Affairs Forecasting and Policy Office Fax on 3-13-03.

Total VHA Enrollee Growth

(by Priority and FY)



Sources: FY 99-02 data are from an Excel file e-mailed to VVA from the VHA Policy and Forecasting office titled"enrollees and pts fy99-04 by priority.xls." FY 03 & 04 estimates are from the same office and utilize the full demand figures. 7A-7C are previous designations for the current priority 7 and 8 categories.

VVA's POSITION

The highest legislative priority of Vietnam Veterans of America is the institution of obligatory, or assured, funding for veterans health care, funding that is based on the per capita use of the veterans health-care system (including long-term care) at the 1996 level of funding, indexed for medical inflation. Why the "accepted" level of care at the rates expended in FY 96? Because that's when the law was passed, even though FY 96 was not at the time considered a banner year for medical appropriations by anyone familiar with the process.

VVA initially acknowledged that for the VA to adequately minister to the core groups eligible to receive care at its facilities, the course of action taken by Secretary Principi, while wrenching, was justified and even necessary – but only as a stopgap, temporary palliative. It was the only reasonable action he could take to stanch the hemorrhaging of the system and prevent its collapse. VVA strongly opposes making this exclusion of Priority 8 veterans permanent. VVA has asked that Congress direct that the VA use numbers for its future planning and projection purposes that include provision of services to Priority 8 veterans.

VVA is gratified that the hue and cry raised by veterans service organizations is finally being heard by Congress. Several measures are being considered that would, if a bill is finally enacted, restructure the way medical operations of the VA are funded and effectively remove the annual uncertainty over the VA's budget for health care. The time for serious consideration of these measures is now. A government that can afford to outlay billions for a war against terrorism can find the funding, and reconfigure the funding mechanism, to help heal the veterans of this war and the wars that preceded it.

With funding uncertainties removed, the VA leadership could focus on implementing measures to create a true veterans health-care system, a system in which every veteran who enrolls would be given a full physical examination that would include a comprehensive military health/medical history, a psychosocial workup, and the drawing of blood samples.

This history would provide an epidemiological baseline to help measure future health conditions not only for a particular veteran but potentially for others with whom (s)he served. When an extensive epidemiological database is finally compiled, it can serve as an invaluable tool for physicians. With more information about a patient's military background, a doctor would know to test for particular conditions, parasites, and toxic exposures that may already be adversely affecting the health of that veteran. Such a database could reveal whether others who served in the same outfit reported similar conditions. It would not only help a doctor render an accurate diagnosis and establish an effective treatment plan, it would enable the VA to more effectively identify occupational illnesses and diseases that may be connected to a veteran's military service. Such a database, if accessible to private physicians – and the vast majority of veterans are not enrolled in the VA health-care system – can inform these medical professionals about potential health issues in their patients.

ADJUSTING the FUNDING BASE for VA MEDICAL OPERATIONS

VVA believes, however, that in addition to restructuring the way in which the medical operations of the VA are funded, an adjustment to the base funding must be made.

The percentage increases appropriated for VA medical operations from FY 2002 to FY 2003, and the proposed increase from FY 2003 to FY 2004, are reasonable, even generous. However, the base upon which these increases are predicated is inadequate. The "should-spend" budget illustrated by Graph 1 on page 5 illustrates why. VA officials acknowledge they require an infusion of $1.2 billion over and beyond

the amount appropriated by Congress for FY 04 to reopen the system to Priority 8 veterans. This translates to an appropriation of $28.5 billion in FY 04. And the VA needs $8-10 billion more to effectively comply with the law and meet the 1996 "level of effort" for veterans health care. Using very conservative figures for medical inflation, funding of the VA's medical operations should be some $36 billion for FY 04.

Congress must revisit this issue and consider ways to right this wrong as part and parcel of any move to rework the way the VA health-care system is funded. Whether additional funding is on-budget or off-budget, or whether these additional funds are "discretionary," "mandatory," "assured," or "obligatory," the funding base for the veterans health care must be restored to the proper level, starting the next fiscal year.

TOWARD REAL ACCOUNTABILITY

VVA has long maintained that managerial accountability goes hand-in-hand with obligatory funding. The entire VA system warrants continued management systems reforms, the prime goal of which must be to ensure the accountability of senior managers.

The VA's focus on accountability concentrates on providing incentives to senior managers, rewarding those who perform their jobs adequately with annual bonuses that average almost $11,000. There are few, if any, sanctions imposed on those managers who demonstrate incompetence or recalcitrance to do what they are paid to do. It is useful to note that a VISN director and a director of a VA Medical Center received bonuses greater than $10,000 for several years even after lice had been found in the bodies of veterans under their care.

While many very fine managers who are able leaders and dedicated public servants are employed by the VA, there are others who don't feel compelled to act in the manner of true public servants. Rarely if ever is a senior manager denied a bonus, even in instances in which that manager is known to have ignored directives or deliberately misled top officials at the VA.

While there is a legitimate need to make significant adjustments in the compensation for critical health-care workers, the current use of "merit bonuses" has been corrupted. Merit bonuses must be just that: bonuses for merit and achievement above and beyond that which is required. The current mode does a disservice to the many fine VA physicians and administrators who deserve more competitive pay and bonuses for truly outstanding performance. The system of rewards and punishment must be adjusted to sanction those who do a poor job or are not fully open and honest with appointed or elected officials.

To ensure accountability, the VA must develop a modern financial tracking system and standardize its financial systems so that the costs at one medical center can be easily tracked and compared to similar expenditures at other VA medical centers. Similarly, the VA must develop a real-time Management Information System (MIS) to track how many clinicians or specialists are available at each medical center at any given time. VVA believes that the VA must subscribe to the old military adage that "a unit does well which the commander checks well."

CONCLUSION

We as a nation can and must do better for our veterans. Funding for veterans health care has been woefully inadequate for years. As Dr. Linda Spoonster Schwartz, then chair of VVA's National Veterans Healthcare Committee (and currently Commissioner of Veterans Affairs for the State of

Connecticut) testified before Congress: "The lack of a consistent, reliable budget has, in essence, obstructed VA's capacity to respond to the changing needs of the health-care system, to efficiently grow, to acquire competent personnel and maintain a viable service infrastructure." And as the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans has concluded: "Funding provided through the current budget and appropriations process for VA health care delivery has not kept pace with demand, despite efforts to increase efficiencies and focus health care delivery in the most cost-effective manner. . . . Full funding should occur through modification to the current budget and appropriation process by using a mandatory funding mechanism, or by some other change in the process that achieves the desired goal."

VVA believes it is imperative to enact legislation that would mandate obligatory funding for veterans health care. Such legislation would make moot the issue of eligibility of Priority 8 veterans to receive medical services from the VA. Making veterans' health-care funding obligatory would eliminate the annual uncertainty about funding levels that has prevented planners at the VA from meeting the needs of the growing number of veterans seeking treatment. An assured, steady funding stream would enable the VA to concentrate on achieving accountability for performance from senior managers and building a system that is not only cost-effective and cost-efficient, but truly contributes to the mission of restoring veterans who have been lessened physically through injury or illness or the psychic wounds of war, or economically by virtue of military service.

To rectify past injustices, the system must be funded at a level that will enable Secretary Principi to re-open the VA health-care system to new enrollees who may be classified as Priority 8. It is imperative that at least $28.5 billion (in addition to projected third-party payments of $1.7 billion) be appropriated by Congress for VA medical operations for FY 04.

VVA and other VSOs believe it is disingenuous for our government to promise health care to veterans and then fail to provide adequate funding. Rationed health care must only be a temporary expedient as Congress moves toward an obligatory funding model. We endorse the proposition that "by including all veterans currently eligible and enrolled for care, we protect the system and the specialized programs VA has developed to improve the health and well-being of our nation's sick and disabled veterans." We expect our government to respect the covenant and honor its commitment and our obligation to those who have placed life and limb in harm's way.

APPENDIX

EXPLANATION OF PRIORITY GROUPS 1-8

The following is taken from the VA Web site, www.va.gov:

In October 1996, Congress passed Public Law 104-262, the Veterans' Health Care Eligibility Reform Act of 1996. This legislation paved the way for the creation of a Medical Benefits Package - a standard enhanced health benefits plan available to all enrolled veterans. Like other standard health care plans, the Medical Benefits Package emphasizes preventive and primary care, offering a full range of outpatient and inpatient services.

VA places a priority on improved veteran satisfaction. Our goal is to ensure that the quality of care and service you receive is consistently excellent, in every location, in every program. Under the Medical Benefits Package, VA offers you, the veteran, a comprehensive health care plan that provides the care you need.

What are the Priority Groups?

Once you apply for enrollment, your eligibility will be verified. Based on your specific eligibility status, you will be assigned a priority group.

The priority groups are as follows, ranging from 1-8 with 1 being the highest priority for enrollment. Under the Medical Benefits Package, the same services are generally available to all enrolled veterans.

As of January 17, 2003, VA is not accepting new Priority Group 8 veterans for enrollment (veterans falling into Priority Groups 8e and 8g.)

Priority Group 1

- Veterans with service-connected disabilities rated 50 percent or more disabling

Priority Group 2

- Veterans with service-connected disabilities rated 30 percent or 40 percent disabling

Priority Group 3

- Veterans who are former POWs
- Veterans awarded the Purple Heart
- Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty
- Veterans with service-connected disabilities rated 10% or 20% disabling
- Veterans awarded special eligibility classification under Title 38, U.S.C., Section 1151, "benefits for individuals disabled by treatment or vocational rehabilitation"

Priority Group 4

- Veterans who are receiving aid and attendance or housebound benefits
- Veterans who have been determined by VA to be catastrophically disabled

Priority Group 5

- Nonservice-connected veterans and noncompensable service-connected veterans rated 0 percent disabled whose annual income and net worth are below the established VA Means Test thresholds
- Veterans receiving VA pension benefits
- Veterans eligible for Medicaid benefits

Priority Group 6

- Compensable 0 percent service-connected veterans
- World War I veterans
- Mexican Border War veterans
- Veterans solely seeking care for disorders associated with:
  - exposure to herbicides while serving in Vietnam; or
  - exposure to ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki; or
  - for disorders associated with service in the Gulf War; or
  - for any illness associated with service in combat in a war after the Gulf War or during a period of hostility after November 11, 1998.

Priority Group 7

Veterans who agree to pay specified co-payments with income and/or net worth above the VA Means Test threshold and income below the HUD geographic index

- Subpriority a: Noncompensable 0 percent service-connected veterans who were enrolled in the VA Health Care System on a specified date and who have remained enrolled since that date
- Subpriority c: Nonservice-connected veterans who were enrolled in the VA Health Care System on a specified date and who have remained enrolled since that date
- Subpriority e: Noncompensable 0 percent service-connected veterans not included in Subpriority a above
- Subpriority g: Nonservice-connected veterans not included in Subpriority c above

Priority Group 8

Veterans who agree to pay specified co-payments with income and/or net worth above the VA Means Test threshold and the HUD geographic index

- Subpriority a: Noncompensable 0 percent service-connected veterans enrolled as of January 16, 2003, who have remained enrolled since that date
- Subpriority c: Nonservice-connected veterans enrolled as of January 16, 2003, who have remained enrolled since that date
- Subpriority e: Noncompensable 0 percent service-connected veterans applying for enrollment after January 16, 2003
- Subpriority g: Nonservice-connected veterans applying for enrollment after January 16, 2003

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Vietnam Veterans of America
8605 Cameron Street
Suite 400
Silver Spring, Maryland 20910
301-585-4000
www.vva.org

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AMVETS

NATIONAL
HEADQUARTERS
4647 Forbes Boulevard
Lanham, Maryland
20706-4380
TELEPHONE: 301-459-9600
FAX: 301-459-7924
E-MAIL: amvets@amvets.org

Testimony

of

Richard "Rick" Jones
AMVETS National Legislative Director

before the

Committee on Veterans' Affairs
Subcommittee on Health
U.S. House of Representatives

on

1. **H.R. 2379, a bill to improve access to health care for rural veterans; and,**
2. **H.R. 3094, a bill to establish standards of access to care for veterans seeking health care from the Department of Veterans Affairs.**

Tuesday, September 30, 2003
2:30 PM, Room 340
Cannon House Office Building

Chairman Simmons, Ranking Member Rodriguez, and Members of the Subcommittee:

On behalf of AMVETS National Commander S. John Sisler and the nationwide membership of AMVETS, I am pleased to offer our views to the Subcommittee on Health regarding access to care and the consideration of two health care bills, H.R. 2379, introduced by Representative Tom Osborne, and H.R. 3094, introduced by Representative Ginny Brown-Waite.

For the record, AMVETS has not received any federal grants or contracts during the current fiscal year or during the previous two years in relation to any of the subjects discussed today.

Mr. Chairman, AMVETS has been a leader since 1944 in helping to preserve the freedoms secured by America's Armed Forces. Today, our organization continues its proud tradition, providing, not only support for veterans and the active military in procuring their earned entitlements, but also an array of community services that enhance the quality of life for this nation's citizens.

Both of the bills before the panel address concerns voiced by AMVETS and other veterans service organizations in the past. Indeed, there are many strong challenges facing veterans from rural areas seeking VA health care, not the least of which is the absence of a full range of healthcare services in isolated communities. And, I think we all would agree that timely access to health care is an important part of our national priority to provide veterans the benefits earned in military service to our country.

Clearly, providing the best possible health care to our Nation's veterans is a difficult task given the current circumstances of chronic underfunding. VA already struggles with an inadequate budget and too many veterans are barred from access for reasons unrelated to the distance they reside from medical facilities.

A short year ago, over 300,000 veterans, regardless of where they lived, waited six months or more for an initial doctor's appointment. Today, we are informed that this situation has changed. VA now estimates that the waiting list is down to approximately 57,000 servicemembers.

However, the total number of veterans waiting for care still remains high because since last January more than 167,000 veterans have been totally barred from the system.

It will not be easy to resolve this access to care issue. As we watch this year's appropriations process our concerns rise knowing that too many sick and disabled veterans may have to continue their wait. It is important, nonetheless, that we do our honest best to meet our promise to provide quality health care in return for military service in defense of this country.

H.R. 2379, Rural Veterans Access to Care Act of 2003

As introduced, H.R. 2379 would allow the VA to contract for care with local medical providers in instances where the veteran would otherwise have to travel at least 60 minutes or greater for VA care.

While it may be impossible to expect that every veteran living in a rural area can find every VA healthcare service close at home, specialized and otherwise, it is essential that we work together to better serve these men and women who served in military uniform.

As a way to reduce the inequities in the delivery of VA healthcare services, H.R. 2379 may have merit. Clearly, sick or disabled veterans should not be overlooked simply because they live in a sparsely populated area. However, AMVETS is concerned with the provision that earmarks 5-percent of VA medicalcare funds to local contracts outside the VA system.

AMVETS believes that the more practical way to meet the challenge is to open community-based outpatient clinics to bring primary health care closer to veterans. This type of approach would help us to meet our commitment to veterans in rural areas. The one caveat, however, is to ensure that the provision of these much needed services do not displace VA's obligation to fund quality specialized programs such as blind rehabilitation and spinal cord injury care to the veterans who need it.

H.R. 3094, Veterans Timely Access to Health Care Act

Regarding H.R. 3094, AMVETS firmly supports the goal of requiring timely attention to the healthcare needs of veterans. Establishing a 30-day standard of access for veterans seeking health care from VA would attain a measurement of success that we have recommended numerous times over the years to this panel and other congressional forums, including the appropriations subcommittee.

Despite VA's establishment of such a goal in 1995, the Government Accounting Office reported in 2001, meeting the 30-day standard is a continuing challenge for many clinics across the system. It is clear that meeting this level of success requires more than good intentions and the setting of a national goal to get the job done.

It is yet in question as to whether success can be found in legislative dictate. In 1996, Congress required VA to ensure that veterans enrolled in its healthcare system receive timely care. As a result, VA refined its goals to the 30-30-20 principle: routine primary care appointments would be scheduled within 30 days, as would specialty care appointments, and patients would be seen within 20-minutes of their scheduled appointment.

As the President's Task Force to Improve Health Care Delivery For Our Nation's Veterans noted, to ensure the most cost-effective and timely delivery of quality care arrangements must be implemented that result in maximizing resources. Of course, the task force also concluded that "the current mismatch in VA between demand and available funding…impedes veterans' access to (timely) care."

Further on the funding mismatch, the PTF said "despite efforts to increase efficiencies and deliver health care in the most cost-effective manner… the funding provided through the current appropriations process for VA health care delivery has not [ed. repeat not] kept pace with demand."

AMVETS strongly supports the 30-day standard. Moreover, we believe that timely access to the full range of health benefits earned through military service to their country is a national obligation to our veterans – whether living in rural, urban or suburban America.

However, the improvement of health care delivery is dependent on a number of elements that may be beyond the reach of standard setting. Key among these, we believe, is funding. Without doubt, inadequacies within VA's budgets in recent years have truly challenged its ability to sustain its enviable position as a high quality healthcare provider.

The members of AMVETS have watched as overworked medical staffs attempted to carry on, but the bottom line is that vital services have been reduced or eliminated; medical care has been rationed; and in the process, the veterans' population has been woefully underserved.

We believe that VHA is currently well led. We also believe that efficiencies can be found that strengthen VA's management of clinical functions. Nevertheless, adequate funding will remain central to VA's ability to sustain timely delivery of quality health care to our veterans. Improving the standard for being seen by a VA doctor is critical, of course, to improving general health care. However, our best analysis of this matter identifies inadequate funding as the central issue challenging the VA healthcare system.

Mr. Chairman, in closing, AMVETS looks forward to working with you and others in Congress to find the best ways to extend health care to veterans in rural areas and to ensure the earned benefits of all of America's veterans are strengthened and improved. As we find ourselves in times that threaten our very freedom, our nation must never forget those who ensure our freedom endures. AMVETS thanks the panel for the opportunity to address this matter.

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES

CHAIRMAN SIMMONS TO DEPARTMENT OF VETERANS AFFAIRS

Questions for the Record
Honorable Rob Simmons, Chairman
Subcommittee on Health
Committee on Veterans' Affairs
September 30, 2003

Access to Care and Consideration of H.R. 2379 & H.R. 3094

Question 1: In April 2001, your predecessor Dr. Thomas Garthwaite testified before this Subcommittee that it was VHA's goal to ensure that at least 90% of its patients were able to receive primary care appointments within 30 days of need. Is this still your policy as well as the goal of H.R. 3094?

Response: It is VHA's goal to schedule a primary care appointment within 30 days of a patient's need, i.e., within 30 days of the date the patient desires or the date the provider has indicated he or she wants the patient to return. VHA monitors the percent of all appointments scheduled within 30 days of desired date. This is a better measure of VA's ability to meet the needs of its patients since many patients do not want or need to be seen within 30 days of contacting the VA for an appointment. The vast majority of appointment requests are for a return follow-up appointment. These types of appointments are most often for a future date that is well beyond 30 days from the date that the veteran contacted the facility for an appointment (e.g. 6-month return follow-up visit).

Question 2: In your written statement you testified: *"At this point in time, we don't believe any of our VISNs would be able to comply with the 30-day standard for 90 percent of patients seeking primary care during the first quarter of 2004."* This statement seems to indicate that none of VA's health care networks meets your current, published waiting standards. What is the consequence of a network failing to meet access standards in your Administration? Please also describe your recommendations and strategic plans for networks to meet the VA-established access standards.

Response: H.R 3094 describes the standard for access to care as within 30 days from the date a veteran contacts, a VA health care facility until the date the veteran is seen by a primary care provider. As noted in our testimony, we believe that none of the VISNs would be able to comply with this 30-day standard for 90 percent of patients seeking primary care during the first quarter of CY 2004.

The following chart provides the compliance rates for appointments for the month of September 2003. The second column shows the percent of all appointments seen within 30 days of when the veteran contacts a VA facility. The third column shows the percent of all appointments seen within 30 days of the desired date, which is our preferred measure of our success in meeting our patients' needs and desires for appointments.

VISN	Pct of ALL Appointments seen in 30 days of date veteran contacts facility	Pct of ALL Appointments seen in 30 days of Desired Appointment Date
1	39.1%	91.1%
2	39.6%	96.3%
3	56.7%	97.4%
4	36.3%	94.3%
5	47.4%	92.7%
6	45.0%	93.9%
7	40.0%	89.3%
8	40.1%	92.9%
9	41.6%	95.0%
10	39.3%	93.0%
11	33.3%	91.9%
12	47.6%	93.3%
15	35.4%	93.7%
16	47.6%	97.2%
17	47.0%	89.0%
18	43.1%	97.2%
19	41.0%	87.9%
20	71.9%	89.2%
21	51.1%	94.0%
22	53.9%	92.2%
23	34.3%	92.6%

VA operated on a Continuing Resolution for over one-third of the year before increased funding was made available. Despite this delay and the resulting need to postpone hiring critical staff to expand our primary care capacity, VA has made great progress in reducing the numbers of veterans waiting more than 6 months for care. As of October 15, 2003, this list totaled 43,271 as compared to over 300,000 in July 2002. It should be noted that, although we have eliminated enrollment of new priority 8 veterans, enrollment continues to increase. Nonetheless, VA anticipates eliminating the wait list by the end of February 2004. The improvement in patient waits and reductions to the waiting list have occurred while increasing workload demands have been place on the system.

VHA has undertaken many actions to address waiting times and wait lists. For the past several years, VHA has been working on implementing the principles of Advanced Clinic Access (ACA). This ACA initiative is oriented to meeting the demand of our patient population for care at the time the request is made.

By utilizing the key components of our ACA initiative, clinics are able to make office practice efficiencies that ultimately result in increased capacity. Only when a clinic has made all of the identified efficiencies can one truly justify increased resources. In the past, many providers and managers were frustrated in that

requests for additional resources were not addressed. With ACA, providers can now provide the necessary data for addressing the resource issue.

VHA has developed an infrastructure to sustain improvement gained from ACA implementation and to facilitate the spread of ACA across the VA health care system. The infrastructure includes:

- VA established an Advanced Clinic Access Steering Committee, chaired by a VISN director, and charged with oversight of ACA implementation. The Steering Committee is now in its fourth year of operation.
- The steering committee appointed liaisons to each of the six performance measure clinics. These liaisons have established regular conference calls to accelerate the spread of ACA. Attendance at these calls ranges from 50 to 100 clinicians per call.
- VHA has developed a network of ACA coaches/experts who have implemented ACA in their own clinics and are willing and able to teach others. Four meetings of ACA coaches designed to further the development of these coaches and to develop additional coaches have been held over the last three years. Regional conferences across the country are planned for the spring of 2004.
- Additionally, VHA has established ACA Points of Contact in each VISN and each facility. Each VISN has developed a plan for implementation of ACA.
- In October 2002, VHA appointed a full-time Clinical Program Manager to continue the work begun by IHI and provide coordination and oversight of the implementation of ACA across all of its clinics.

Oversight of ACA implementation is accomplished through regular review of the data related to waiting times, daily communication between the VHA program manager and the field, and articulation of the importance of ACA implementation by VHA senior leaders. A handbook outlining the ACA principles and implementation strategies will be published this spring. In addition performance on waiting times is factored into each Network Director's performance evaluation. We discuss their performance quarterly and have emphasized the need to assign resources to address the waiting time issue.

VHA also developed an electronic wait list (EWL) that facilities are using as a management tool to track veterans who are waiting for an appointment to be scheduled. National monthly reports provide information about the number of patients waiting for care at VA facilities and the length of time that they have been on the wait list.

Question 3: Your written statement suggested that it is the Administration's view that H.R. 3094 would result in new veterans flocking to VA in order to gain access to contract care. In your written statement you testified: "*The Administration preliminarily estimates that the increased demand for VA health care resulting from enactment of the bill could run into the billions.*" VA has already excluded priority 8 veterans from enrolling, and you have asked

Congress to make this exclusion permanent by law. Also, VA announced a new transition pharmacy benefit for those enrolled and now waiting for care. Finally, you have testified that your waiting list is falling dramatically and should soon disappear. Given these facts, what justifies your assertion that veterans would flock to VA as a consequence of enactment of this bill?

Response: See VA response to question 4.

Question 4: Your data show that priority 7 veterans are a very small segment of overall VA demand (about 1.5%). Since the veterans who would be affected by H.R. 3094 are not new priority 8 veterans (now excluded from enrolling), what group of veterans do you foresee would emerge and enroll for the purpose of demanding VA contract their care to private providers?

Response: Although new priority 8 veterans have been excluded from enrollment, total enrollment continues to increase by approximately 25,000 per month. VA anticipates that a combination of factors would place significant additional stress on the health care system. There are approximately 9.43 million non-enrolled veterans who would be eligible to enroll in Priorities 1-7 during FY 2004. VA is concerned that many additional veterans, currently being served by private sector providers, would enroll and request a primary care appointment in order to have VA pay for their private sector care. Those likely to choose this benefit would be, for the most part, veterans with private insurance or public coverage who have significant out of pocket costs or limited prescription drug coverage but who have not yet enrolled because they choose to receive their care in the private sector. Private providers and group practices would also likely channel their veteran patients to this program in order to improve reimbursement for their costs and reduce their patient's out-of-pocket expenses. Thus, VA anticipates that the increased demand for primary care and related specialty care resulting from enactment of this legislation would be significant.

Question 5: In your remarks during our hearing you stated: *"In numerous indicators, VA care is increasing recognized as being of very high quality. I would hate to see that progress, that expanded access,[and] the quality of care be destroyed in our enthusiasm and haste to bring everybody who needs care into a system."* Please explain how in your view the quality of VA care would "be destroyed" as a consequence of enactment of H.R. 3094.

Response: Consistent delivery of high-quality health care requires due attention to at least three key elements: selection of and focus on meaningful performance targets linked to an accountability framework; alignment of resources in a systematized and equitable manner; and adequacy of resources to meet all appropriate clinical needs. Enactment of H.R. 3094 would adversely impact all three elements. The legislated targets would distort the focus from a balanced set of measures addressing quality, cost, access, satisfaction, healthy communities and functional status to a narrow focus on access alone. Moreover, given the reality of limited funds, all increased costs attendant with enactment of H.R. 3094 would divert resources from other important clinical needs in an

inequitable manner, since the contracting requirement of the bill would not account for variation in the clinical needs among veterans. Contracting for care is often more costly than care provided directly by VA, thus the added costs would result in fewer providers, fewer support staff and necessary medications, and fewer supplies and patient education materials that play an important role in quality of care. The major impact of this proposed bill would be the disruption of the continuity of care for established patients and the fragmentation of care for new patients.

Question 6: Does your testimony suggest a belief within the Department that H.R. 3094 intends that VA become an insurance plan for veterans to access private health care?

Response: We do not believe that the intent behind H.R. 3094 is that VA should become an insurance plan for veterans. It is our view, however, that this bill has the potential for dramatically increasing demand for VA care and overwhelming our ability to provide care in VA-operated facilities. Because we don't believe any of our VISNs would be able to comply with the requirements of the specified 30-day standard, every VA facility would have to offer veterans the opportunity to receive primary care in the private sector on a contractual basis. We believe that significant numbers of veterans who now choose to receive their primary care in the private sector would avail themselves of this benefit. The additional demand would have the unintended effect of draining appropriated funds out of VA operated facilities to pay for contract care, which is often more costly than care furnished directly by VA.

Question 7: How do you respond to the concept expressed at the hearing that holding VA's "feet to the fire" with standards of performance will make VA a more efficient organization? Does not the Department's performance over the past 15 months in reducing your longest waits from 300,000 to 60,000 actually prove the point the witness was trying to suggest about accountability bringing about efficiency?

Response: Certainly, VHA's performance measures have been a key driver in holding Networks and facilities accountable for a variety of measures including access standards. In addition, VA has implemented the Advanced Clinic Access initiative that strives to implement office practice efficiencies to free up capacity and improve waiting times.

In 2003, VHA operated on a Continuing Resolution for over one-third of the year before increased funding was made available to the facilities. Despite this delay and the resulting need to postpone hiring critical staff to expand our primary care capacity, VA has made remarkable progress in reducing the numbers of veterans waiting for care. As of October 15, 2003, 43,271 veterans were on the list of patients expected to have to wait six months or more for a non-emergent clinic visit as compared to over 300,000 patients on the list a year earlier. While accomplishing this reduction it should be noted that, total enrollment continues to

increase by approximately 25,000 per month, notwithstanding that new priority 8 veterans have been excluded from enrollment.

VA is an accountable health care system – accountable to the nation's veterans to provide the health care they need and deserve and accountable to taxpayers to assure that tax dollars buy the maximum amount of high quality services for our patients. VA actually leads the nation in its efforts to assure safe and effective services are provided to its patients. VA holds itself out to oversight and review to the same health industry standards as private facilities. As a Federal Department, VA health care is subject to oversight by our Inspector General, the General Accounting Office and other Federal oversight entities and finally, we are subject to the oversight of numerous committees and subcommittees of the congress.

Question 8: While you oppose a bill designed to help veterans and help VA do a better job based on VA's published access to care standards, you testified that you expect the Department to actually achieve the timeliness standards the bill would embrace, with the "help" of this Subcommittee. Without attempting to parse the competing concepts, please explain their meaning to us. What "help" can the Committee provide the Department, if not for bills like these before the Subcommittee?

Response: As we stated in response to question 1, our strategic goal is to schedule all primary care appointments within 30 days of the date the patient desires or the date the provider indicates he or she wants the patient to return. We anticipate being able to meet this standard this fiscal year, negating the need for any legislation. We regret any confusion caused by our statement.

Question 9: Assuming H.R. 2379 would be "unfair" to other veterans as you testified, is the current allocation system fair to veterans who live in rural areas, and what is the basis for this conclusion?

Response: The current allocation is fair to veterans living in rural areas because the allocation price for each patient using the ten price groups under VERA is the same price per patient regardless of whether the patient is from an urban area, a rural area, or a very rural area. The recently completed RAND Phase III study found that patients living in urban areas tend to have higher VA patient care costs than those living in rural areas. RAND did not recommend any change to the VERA model for patients living in either rural or urban areas. An earlier review, which was conducted by VA work groups and was based on an AMA Systems report evaluating rural health care, had similarly found that an adjustment in the VERA model need not be made to account for rural health care.

Question 10: Is there a factor in VERA that deals in any way with the needs of rural veterans? Please explain that factor.

Response: There is no factor in VERA that deals with location (rural or urban) in determining network allocations. VERA patient workload (PRPs – Pro-Rated Patients, based on the relative cost in each network where they receive care) is the basis for allocations using the VERA ten price groups.

Question 11: Do you have data showing that rural veterans receive an equal share of VA health resources compared to their suburban and urban counterparts? Would you share this data with the Subcommittee? If such data does not exist, what is your basis to claim that this bill treats veterans unfairly?

Response: Allocations to networks are based on VERA patient workload (PRPs – see above) using the VERA ten price groups regardless of whether the PRPs are in a rural, suburban, or urban area. For example, a patient in price group 6 in a rural area receives the same allocation as a patient in price group 6 in an urban area. H.R. 2379 would treat veterans unfairly because it would re-direct funding away from current sites to rural areas without any consideration whether appropriate resources are already available to provide needed services.

Question 12: The Subcommittee's understanding is that under CARES, VA assumes that up to 25% of future care to veterans may be accomplished by contract. Currently, overall VA contract care is less than 5% in expenditures. Do you expect Congress to provide VA guidance in the future in how VA should spend these several billions of dollars annually, or would VA resist any such efforts at guidance?

Response: In fact, our projections indicate that the percentage of future workload accomplished through contract care will be considerably less than 25 percent, for both inpatient and outpatient categories (see Attachment 1). Contracted services fall into two general categories. First, Congress has provided specific authority for VA to contract for certain veteran's care when VA facilities are not available and in emergency circumstances. Secondly, Congress has provided adequate authority for VA to enter into contractual arrangements with our affiliates, community providers and sharing partners in order to provide a full continuum of care, or to achieve efficiencies. This second set of authorities are best exercised at local and regional levels so that the unique capabilities of local facilities and the needs of veterans in those areas, and opportunities to generate better value for our patients are the primary considerations. These programs are subject to congressional oversight and as the need arises to modify these authorities we will be happy to work with your committee to develop legislation that will allow us to better serve veterans.

Question 13: Your testimony indicates that any change Congress makes by law could potentially disrupt the VERA system of allocating VA health resources and the CARES initiative examining VA capital infrastructure. Is it your position that Congress should avoid legislating disruptions in VA's internal plans?

Response: The comments in our testimony were based solely on considerations of the specific impacts of H.R. 2379 and H.R. 3094. Our

testimony expressed our belief that these two bills could have the unintended consequence of impairing our ability to manage the VA health care system in a manner that would ensure an equitable level of health care services to all enrolled veterans.

Question 14: In keeping with concerns raised by Mr. Baker and Mr. Murphy during your testimony, please provide the Subcommittee a report of veterans waiting by VISN, as of October 1, 2003, as follows:

Those waiting under 30 days for scheduled appointments.
Those waiting over 30 days but less than 60 days.
Those waiting over 60 days but less than 4 months.
Those waiting over 4 months but cannot be scheduled within 6 months.
Those who are waiting over 6 months but cannot be scheduled within 9 months of seeking care.
Those who cannot be scheduled within one year of seeking care.
Any remaining veterans who cannot be scheduled, with the reasons therefore.

Response: VHA's current software limits us to counts of appointments each month and the percent of those appointments over 30 days. We expect enhancements to our software that will allow us to count patients rather than appointments and more accurately report the distribution of waits. Veterans may have more than one appointment; the extent of duplication is unknown at this point. The tables and graphs in Attachment 2 estimate the distributions in the increments requested.

Note: Attachment 2 is in two parts. The first part responds to all items but the last ("any remaining veterans etc."). The second part responds to this last item.

Question 15: Given your existing policy initiative on reducing your waiting list, when do you project the current waiting list of those waiting more than six months for initial appointments will reach its irreducible minimum?

Response: Last February we forecasted that disallowing new Priority 8 Veterans would accelerate our wait list reduction efforts by a full year. We forecasted that the wait list would be fully eliminated by February 2004 rather than February 2005. As of October 15, 2003, this list had been reduced to 43, 271 and we are on track to eliminate it by the end of February 2004.

Question 16: Assuming that VA will always have finite resources, and that demand from veterans will outstrip supply of VA resources to meet their needs, have you established any parameters to guide field facilities in their management of waiting lists? Please provide the Subcommittee this guidance.

Response: Yes. VA's parameters are to give priority to veterans with service-connected disabilities rated 50 percent or more, veterans seeking care for a service-connected disability, and veterans needing emergent care. We are finalizing policy on various aspects of managing the waiting list and will provide it to the Committee when it has received final approval.

Attachment 1 – Ref Question 12

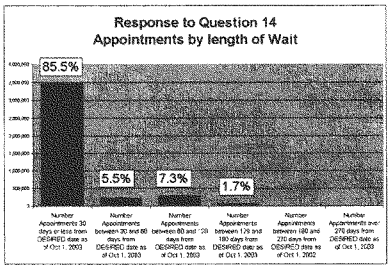
Total Percentage of Workload by Type of Provider for Outpatient

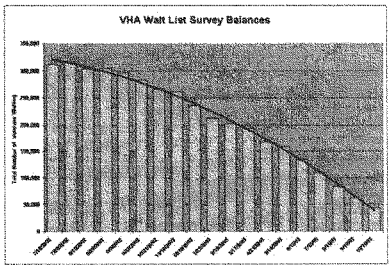
Workload Alternative	Outpatient			
	2012		2022	
	Number of Clinic stops	Percent of Total	Number of Clinic stops	Percent of Total
Contract	***8,011,069***	***15.12%***	***6,189,437***	***13.31%***
Joint Venture	270,258	0.51%	266,600	0.57%
In-Sharing	155,820	0.29%	155,820	0.34%
Sell	1170	0.00%	1,170	0.00%
In-house	44,534,018	84.07%	39,895,682	85.78%
Total Demand	52,972,335		46,508,709	

Total Percentage of Workload by Type of Provider for Inpatient

Workload Alternative	Inpatient			
	2012		2022	
	Bed Days of Care	Percent of Total	Bed Days of Care	Percent of Total
Contract	***606,997***	***10.78%***	***360,301***	***7.77%***
Joint Venture	64,112	1.14%	52,522	1.13%
In-Sharing	12,446	0.22%	12,334	0.27%
Sell	0	0.00%	0	0.00%
In-house	4,947,062	87.86%	4,209,946	90.83%
Total Demand	5,630,617		4,635,103	

Attachment 2 (cont.)





CROSS REFERENCED LIST OF OKLAHOMA-LICENSED OPTOMETRISTS IN THE ASSOCIATION OF REGULATORY BOARDS OF OPTOMETRY'S NATIONAL PRACTITIONERS DATABASE AND MEMBERS OF THE NATIONAL ASSOCIATION OF VETERANS AFFAIRS OPTOMETRISTS

Name:	Name:			
	Michelle Lee Call			
License:	License #:	Original Date:	Last Renewal:	Expires:
	OK-2295	7/27/2000		7/30/2003
	Practice Type:		Status:	ACTIVE
File Last Updated by OK on Thursday, May 08, 2003				

Call, Michelle OD	OK	Wichita VAMC	Wichita VAMC, Specialty Care 11-sc, 5500 East Kellogg, Wichita, OK 67218	316-681-5524	316-579-2755	michelle.call@med.va.gov	

Name:	Name:			
	Geoffrey F. Chiara			
License:	License #:	Original Date:	Last Renewal:	Expires:
	OK-2125	8/8/1994		7/30/2003
	Practice Type:		Status:	ACTIVE
File Last Updated by OK on Thursday, May 08, 2003				

Chiara, Geoffrey F, OD	NV	Eye Clinic - VASNHS	Eye Clinic - VASNHS, Southwest Clinic, P.O. Box 360001 , North Las Vegas, NV 89036	702-636-3023	702-636-4063	geoffrey.chiara@med.va.gov	

Name:	Name:			
	Richard D. Creed			
License:	License #:	Original Date:	Last Renewal:	Expires:
	OK-1148	1/17/1987		7/30/2003
	Practice Type:		Status:	ACTIVE
File Last Updated by OK on Thursday, May 08, 2003				

Creed, Tara	OK	Muskogee VAMC	Muskogee VAMC (11A).1101 Honor Heights Dr., Muskogee, OK 74401	918-680-3667	918-680-3886	Tara.Creed@med.va.gov	

Name:	Name:			
	Charles Noble Davis			
License:	License #:	Original Date:	Last Renewal:	Expires:
	OK-2298	7/27/2000		7/30/2003
	Practice Type:		Status:	ACTIVE
File Last Updated by OK on Thursday, May 08, 2003				

Davis, Charles OD	AR	Fayetteville VAMC	VAMC, 1100 N. College Ave, Fayettevilee, AR 72703	417-466-1135			Charles.Davis8@med.va.gov

Name:	Name:			
	Barry M. Fisch			
License:	License #:	Original Date:	Last Renewal:	Expires:
	OK-2907	8/2/1993		7/30/2003
	Practice Type:		Status:	ACTIVE
File Last Updated by OK on Thursday, May 08, 2003				

Fisch, Barry M OD	MA	Brockton/West Roxbury	Brockton/West Roxbury VAMC, 940 Belmont St. Brocton, MA 02401	508-583-4500x1106			barry.fisch@med.va.gov

Name:	Name:			
	Angela Harris			
License:	License #:	Original Date:	Last Renewal:	Expires:
	OK-2191	8/1/1996		7/30/2003
	Practice Type:		Status:	ACTIVE
File Last Updated by OK on Thursday, May 08, 2003				

Harris, Angela OD	OK	Muskogie VAMC	Muskogee VAMC, 1011 Honor Heights Dr., Muskogie OK, 74401	908-680-3667			Angela.Harris2@e55.med.va.gov

Name:	Name:			
	Lane Toshio Fujimoto			
License:	License #:	Original Date:	Last Renewal:	Expires:
	OK-2273	7/20/1999		7/30/2003
	Practice Type:		Status:	ACTIVE
File Last Updated by OK on Thursday, May 08, 2003				

Fujimoto, Lane OD	NV	Eye Clinic - VASNHS	Eye Clinic- VASNHS , Southwest Clinic , P.O. Box 360001 , North Las Vegas, NV 89036	702-636-3023	702-636-4063	lane.fujimoto@med.va.gov

Name:	Name:			
	Mary Jo Horn			
License:	License #:	Original Date:	Last Renewal:	Expires:
	OK-057	7/11/1995		7/30/2003
	Practice Type:		Status:	ACTIVE
File Last Updated by OK on Thursday, May 08, 2003				

Horn, Mary Jo OD	AR	Fayetteville VAMC	VAMC , 112 Eye Clinic, 100 N. College, Fayetteville, AR 72703	501-443-4301x5678	501-587-5921	mary.horn@med.va.gov

Name:	Name:			
	Linda J.H. Lucas			
License:	License #:	Original Date:	Last Renewal:	Expires:
	OK-2342	7/25/2001		7/30/2003
	Practice Type:		Status:	ACTIVE
File Last Updated by OK on Thursday, May 08, 2003				

Lucas, Linda OD	IL	Marioin VAMC	Marion IL, VAMC, 2401 Main St. Marion, IL 62959	618-997-5311x4679	681-998-5661	Linda.Lucas4@med.va.gov

Name:	Name:			
	Annie Moreau			
License:	License #:	Original Date:	Last Renewal:	Expires:
	OK-2175	8/1/1994		7/30/2003
	Practice Type:		Status:	ACTIVE
File Last Updated by OK on Thursday, May 08, 2003				

Moreau, Annie	OK	Oklahoma City VAMC	VAMC OKC 635/112C, 921 NE 13th St. , Oklahoma City 73104	405-270-0501x 38362	405-290-01714	anniemoreau@hotmail.com

Name:	Name:			
	Lyman C. Norden			
License:	License #:	Original Date:	Last Renewal:	Expires:
	OK-2047	7/22/1991		7/30/2003
	Practice Type:		Status:	ACTIVE
File Last Updated by OK on Thursday, May 08, 2003				

Norden, Lyman OD	AL	Birmingham VAMC	VAMC-Optometry 1112c, 700 S. Fifth St. , Birmingham, AL 35233	205-933-8101x6118	205-933-4484	lyman.norden@med.va.gov

Name:	Name:			
	Dawn Roshell Pewitt			
License:	License #:	Original Date:	Last Renewal:	Expires:
	OK-2231	8/1/1997		7/30/2003
	Practice Type:		Status:	ACTIVE
File Last Updated by OK on Thursday, May 08, 2003				

Pewitt, Dawn	CA	San Diego VAMC	VAMC (112G). 3350 La Jolla Village Dr. San Diego, CA 92161-4189	858-552-8585x4623/22054376	858-552-	dawn.pewitt@med.va.gov

Name:	Name:			
	Clifford A. Scott			
License:	License #:	Original Date:	Last Renewal:	Expires:
	OK-2110	8/2/1993		6/30/2002
	Practice Type:		Status:	Inactive
File Last Updated by OK on Thursday, May 08, 2003				

Scott, Clifford OD, MPH	MA	NEWENCO	NEWENCO, 1255 Boylston St. , Boston, MA 02215	617-369-0198	617-236-6340	scottc@ne-optometry.edu

Name:	Name:			
	Jonathon Charles Thomas			
License:	License #:	Original Date:	Last Renewal:	Expires:
	OK-2379	7/23/2002		7/30/2003
	Practice Type:		Status:	ACTIVE
File Last Updated by OK on Thursday, May 08, 2003				

Thomas, Jonathan OD	NV	Eye Clinic - VASNHS	Eye Clinic-VASNHS, Southwest Clinic, P.O. Box 360001, North Las Vegas, NV 89036	702-636-3023	702-636-4063	jonathan.thomas@med.va.gov

Name:	Name:			
	John C. Townsend			
License:	License #:	Original Date:	Last Renewal:	Expires:
	OK-2085	7/20/1992		7/30/2003
	Practice Type:		Status:	ACTIVE
File Last Updated by OK on Thursday, May 08, 2003				

Townsend, John C OD		Washington DC	Dept. of Veterans Affairs, 810 Vermont Ave. NW, Wahington DC 20420	202-273-8555		john.townsend@mail.va.gov

Name:	Name:			
	David Roy Trout			
License:	License #:	Original Date:	Last Renewal:	Expires:
	OK-2290	7/20/1999		7/30/2003
	Practice Type:		Status:	ACTIVE
File Last Updated by OK on Thursday, May 08, 2003				

Trout, David OD	TX	Amarillo	Amarillo VAMC, 6010 Amarillo Blvd, West, Amarillo, TX 79106			David.Trout@med.va.gov

Name:	Name:			
	Paul W. Varner			
License:	License #:	Original Date:	Last Renewal:	Expires:
	OK-2351	7/25/2001		7/30/2003
	Practice Type:		Status:	ACTIVE
File Last Updated by OK on Thursday, May 08, 2003				

Varner, Paul OD	MO	Poplar Bluff VAMC	VAMC, Eye Clinic (111) 1500 N. Westward Blvd, Poplar Bluff, MO 63901	573-778-4303	573-778-4131	Paul.Varner@med.va.gov

Name:	Name:			
	Katherine L. Wang			
License:	License #:	Original Date:	Last Renewal:	Expires:
	OK-2352	7/25/2001		7/30/2003
	Practice Type:		Status:	ACTIVE
File Last Updated by OK on Thursday, May 08, 2003				

Wang, Katherine	CA	SanDiego VAMC	VA San Diego Health Care System, (112G), 3350 La Jolla Village Dr. , San Diego, CA 92161-4189	858-552-8585x4624	858-552-4376	katherine.wang@med.va.gov